2004 Maryland State Employees Summary of Benefits

IMPORTANT BENEFITS INFORMATION FOR YEAR 2004

READ THIS BOOKLET CAREFULLY & COMPLETELY

CALL: IVR 410.669.3893 OR 1.888.578.6434
Automated Telephone Enrollment,
24 hours a day, 7 days a week during Open Enrollment
Fall 2003 Open Enrollment Dates:
November 17 - December 5, 2003

For more information, visit our website:
http://www.dbm.maryland.gov

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

James C. "Chip" DiPaula, Jr.
Secretary,
Department of Budget & Management

NOTE: The Term Life Insurance Plan is with Standard Insurance Company.

2004 Premium Rates for Term Life Insurance

Age of Employee	Bi-Weekly Employee Rate (per $10,000)	Monthly Employee Rate (per $10,000)	Age of Spouse	Bi-Weekly Spouse Rate (per $5,000)	Monthly Spouse Rate (per $5,000)
Under 20	.29	.58	Under 20	.31	.62
20 to 29	.29	.58	20 to 29	.31	.62
30 to 34	.35	.70	30 to 34	.34	.68
35 to 39	.46	.92	35 to 39	.42	.84
40 to 44	.72	1.43	40 to 44	.62	1.24
45 to 49	1.16	2.32	45 to 49	.96	1.92
50 to 54	1.88	3.75	50 to 54	1.44	2.87
55 to 59	3.24	6.48	55 to 59	2.23	4.45
60 to 64	4.68	9.36	60 to 64	3.41	6.82
65 to 69	6.99	13.98	65 to 69	4.96	9.92
70 to 74	12.51	25.02	70 to 74	7.80	15.60
75 to 79	24.47	48.94	75 to 79	7.80	15.60
80 and older	24.47	48.94	80 and older	7.80	15.60

Dependent Child Coverage is .95 per $5,000 per month

NOTE: The AD&D plan is with the Metropolitan Life Insurance Company.

2004 AD&D Plan Rates

Plan Coverage Level	Employee Only Biweekly	Employee + Family Biweekly	Employee Only Monthly	Employee + Family Monthly
$100,000	$ 0.90	$ 1.65	$ 1.80	$ 3.30
$200,000	$ 1.80	$ 3.30	$ 3.60	$ 6.60
$300,000	$ 2.70	$ 4.95	$ 5.40	$ 9.90

NOTE: There is a dependent verification audit after Open Enrollment. If you added a dependent during open enrollment, you will be required to produce documentation to verify eligibility for the dependent. Ask your Agency Benefits Coordinator about this requirement. If you attempt to add an ineligible person to your coverage, or if you fail to remove a dependent who is no longer eligible, you will be required to pay the full Individual premium for the ineligible person from the date such coverage becomes effective until it is terminated.

NOTICE TO EMPLOYEES AND THEIR DEPENDENTS

The State Employee Health Benefits Program is covered by the Public Health Service Act (PHSA) and the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) which are included in the PHSA. The Program and the plans offered through it are not covered by ERISA. A detailed COBRA Notice to all employees and their dependents that explains COBRA rights and obligations is found in this booklet at page 74..

SUMMARY OF MARYLAND STATE EMPLOYEES HEALTH BENEFITS 2004

TABLE OF CONTENTS

ENROLLMENT INSTRUCTIONS FOR YEAR 2004 BENEFITS

1. **Educate yourself on your Benefits Plan Options.**
   - Carefully Review the information in this book on each of the plans available to you.
   - Call the benefit plan for further information and to request plan literature.
   - Contact your Agency Benefits Coordinator for further information.
2. **Determine if you need to make enrollment changes or selections by using the Interactive Voice Response System (IVR) for:**
   - Enrolling in a new plan for the first time.
   - Cancelling or making a change to your existing plans or coverage levels.
   - Enrolling in Health Care or Day Care Spending Account for Year 2004.

   If you do not enroll in a Health Care or Day Care Spending Account for Year 2004, you will not have a Spending Account in Year 2004.
3. **You must use the IVR system for your Year 2004 Open Enrollment selections. The IVR system allows you to make enrollment selections through a touch-tone telephone (see page 3 for instructions).**
   - Review the following page on how the IVR system works.
   - You will receive a Benefits Statement from your Agency Benefits Coordinator.
   - Review the Benefits Booklet and your Benefits Statement for tips on how to use the IVR system to select your Year 2004 benefits.
   - Review the IVR Benefits Statement before making your IVR call.
   - If you have any questions on the IVR system or you need assistance to use the IVR, please see your Agency Benefits Coordinator.
4. **When you use the IVR for your Year 2004 benefit selections, you will receive a Summary Statement of your Year 2004 benefit selections, confirming the time and date of your call.**

NOTE: You must make your enrollment selections and changes through the IVR by the end of Open Enrollment. Do not send in Enrollment Worksheets. Once you make your selections, they are binding until January 1, 2005 unless you have a qualifying change in status.

NOTE: If you add dependents during Open Enrollment, you must supply your Agency Benefits Coordinator with proper documentation (see Required Documentation for Dependents) within 30 days of the date of your IVR call. If you do not supply your Agency Benefits Coordinator with these documents by the deadline, your dependents are not eligible for coverage. Even if you receive a membership card; your dependent is not eligible for services. A dependent may be listed on the employee's dependent file, however, if the Agency Benefits Coordinator does not receive the required documentation, your dependent is considered as an ineligible dependent. IF YOU ATTEMPT TO ADD AN INELIGIBLE PERSON TO YOUR COVERAGE, OR IF YOU FAIL TO REMOVE A DEPENDENT WHO YOU CAN'T PROVIDE THE REQUIRED DOCUMENTATION FOR, YOU WILL BE REQUIRED TO PAY THE FULL INDIVIDUAL PREMIUM FOR THE INELIGIBLE PERSON FOR EACH MONTH THAT THE DEPENDENT REMAINED ENROLLED.

Visit us at our website: www.dbm.maryland.gov (Click on the Employee Services tab)

Interactive Voice Response (IVR) Enrollment For Year 2004 Benefits

Call 410-669-3893 or 1-888-578-6434
24 hours a day, 7 days a week during Open Enrollment

- During Open Enrollment for Year 2004 benefits, you must use the Interactive Voice Response (IVR) system to enroll, make changes to your benefits, and add or delete dependents.
- The IVR is an automated telephone enrollment system. You must call the IVR using a touch-tone telephone.
- The IVR will be available 24 hours a day, 7 days a week during Open Enrollment.
- For Open Enrollment, you will receive a personalized Benefits Statement. The Statement contains pre-printed information about yourself and benefits coverage for Year 2004. Please review the Statement carefully before making your telephone call.

GET READY TO CALL:

- After you have read your Benefits Booklet and reviewed your Benefits Statement, you are ready to call!
- Have your Benefits Statement and Benefits Booklet with you next to your telephone when you make your call.
- Call 410-669-3893 (Baltimore area) or 1-888-578-6434 (outside Baltimore area).
- The IVR automated attendant will then guide you through the system for Medical, Prescription Drug, Dental, Personal Accident and Dismemberment, Spending Account, Life Insurance, and adding and deleting dependents.
- After each and every selection you make, the IVR automated attendant will confirm what you selected. You will then be able to confirm this selection or cancel it right then and make a different choice.
- If you need to add a dependent(s), delete a dependent(s), or make changes to a dependent(s) information (such as their Social Security Number), you will also be able to do this using the IVR.

  The IVR automated attendant will ask you to Speak and Spell your dependents name:

  -- You will first Speak the name of your dependent (First Name, Middle Initial, Last Name). Please speak slowly.

  -- You will then Spell the name of your dependent (First Name, Middle Initial, Last Name). Please spell clearly.
- The IVR will then ask you to provide various information about your dependents, such as their Date of Birth and their Relationship to you. Do not use the touch tone pad for numbers. You must speak the number to be recorded.
- If you need assistance using the IVR, contact your Agency Benefits Coordinator in your Personnel Office.
- An updated Summary Statement of Benefits will be sent to you through your Agency Benefits Coordinator within 10 days after your IVR telephone call. The Summary Statement will list what benefits you have chosen for Year 2004, and confirm the date of your IVR telephone call. Review the Summary Statement carefully to confirm that the changes are correct. If the charges are not correct, call the IVR again to make the correct changes. You cannot correct any mistakes after Open Enrollment is over.
- As the IVR is available 24 hours a day, 7 days a week during Open Enrollment, you can make further changes using the IVR throughout Open Enrollment.
- Although the IVR is available 24 hours a day, the best time to use the IVR is during the **non-peak hours of late evening to early morning.**

NOTE: It is also best not to wait until the last few days of Open Enrollment, when you may have a greater chance of getting a busy signal. Make your changes early.

OVERVIEW OF PLANS

The State of Maryland offers its employees a wide range of health benefits. Please review the following descriptions of coverage carefully to choose the types best suited to your needs. This information is intended only as a general overview of available options. If you require specific information about coverage, limitations, exclusions, participating providers, or preauthorization requirements of the various plans, you must contact the plans directly. Each plan has dedicated service representatives that handle State employees' and retirees' accounts. The plans' service representatives have the most current information available to assist you with any questions you may have about the plan's coverage. Plan phone numbers and websites are located on the back cover of this book.

Cafeteria Plan: The State offers employees a cafeteria plan under Section 125 of the Internal Revenue Code. A cafeteria plan is an employer-provided health benefits plan which offers employees the opportunity to choose among non-taxable and qualified benefits. Qualified benefits are nontaxable benefits such as medical or dental coverage. If you choose to enroll for coverage for qualified benefits, the amount you pay for premiums is tax-free. It will not be included in your gross income for the plan year. The following available benefits are qualified benefits:

- Medical
- Prescription
- Dental
- Mental Health/Substance Abuse
- Term Life Insurance up to $50,000 for employees. (Higher coverage levels are taxable.)
- Accidental Death & Dismemberment Plan (AD&D)
- Flexible Spending Accounts

Please note that there are benefits available that are not tax-free, such as term life insurance for dependents or for employee amounts over $50,000, long term care premium deductions, and premium deductions for retirees for all plans.

NOTE:

- **Vision benefits are included under your medical plan coverage. If you are not enrolled in a medical plan, you do not have vision benefits.**
- **You must be enrolled in a dental plan to have dental benefits.**
- **If you move and/or live out of State, please contact the medical plans and dental HMO plan(s) to confirm that the plan(s) service your area. If the medical plan and/or dental HMO plan does not service your area, you must select a plan which does provide service.**

Additionally, you will receive a Summary Plan Description from your plan after you enroll, giving you a detailed listing of coverage, limitations, and exclusions that are specific to your plan. This booklet is not a contract. The terms set forth in the State contract with the plan shall prevail.

PLAN TYPE	BENEFITS IN THE YEAR 2004
Medical Plan	2 Preferred Provider Organizations (PPO) Plans 3 Point-of-Service (POS) Plans 3 HMO Plans All medical plans include vision benefits No dental benefits or prescription benefits are included in any medical plan.
Prescription Plan	Prescription drug coverage.
Dental Plan	Three dental plan options: two Dental Health Maintenance Organizations (DHMO), or a Dental Point-of-Service (POS) plan. No dental benefits are included in any medical plan.
Mental Health/ Substance Abuse Plan	Coverage for treatment of mental health disorders and substance abuse. If you choose PPO or POS medical plan, all your mental health and substance abuse treatment must be through the Mental Health/ Substance Abuse plan. If you choose an HMO medical plan, your Mental Health/Substance Abuse treatment will be through your HMO.
Term Life Insurance	Up to $50,000 in coverage without Medical Review. Up to $300,000 in coverage with Medical Review. Coverage also available for dependent(s).
Accidental Death & Dismemberment Insurance	Lump sum payment if you suffer dismemberment or death due to an accident.
Flexible Spending Accounts	Tax-free reimbursement accounts for eligible expenses for either medical coverage or day care of eligible dependents.
Long Term Care	Coverage for Nursing Home Care, Assisted Living Care, Adult Day Care, etc., for covered members with Activities of Daily Living (ADL) certified disabilities.

Plan Descriptions: All Plan descriptions in this book adhere to a similar format and include sections on:

- **General Description of Plan**
- **How to Receive Plan Benefits**
- **Questions?**
- **Plan Benefits Chart**

Please refer to these sections to find the information you need. We have also included a glossary and index to further assist you in finding health benefits information in this book.

MEDICAL

MEDICAL PLANS

General Description of Coverage

Medical coverage is available to all individuals and their dependents who are eligible for health benefits with the State. There are three types of medical plans offered: Preferred Provider Organization (PPO), Point-of-Service (POS), and Health Maintenance Organization (HMO). While all three types of plans offer comprehensive coverage, the type of medical plan you choose determines your premium, out-of-pocket expense, and choice of physician. Please remember that any medical treatment must be considered a "medical necessity" by your plan in order for payment to be authorized. The following chart gives a general overview of the differences in types of plans.

Choices in Medical Coverage

Type of Plan	Basic Format	Premium	Choice of Physician	Copay	Out-of-Network
PPO • Carefirst Blue Cross Blue Shield • MLH Eagle	May choose any physician, but choice determines out-of-pocket expense.	Highest premium	Any PPO or Non-PPO physician at time of service. No need for plan referral to a specialist.	PPO Physician: $15 Primary Care $20 Specialist Care	Out-of-Network services subject to a deductible and 20% coinsurance.
POS • Aetna Quality QPOS • Carefirst BCBSM Maryland POS • M.D.IPA Preferred	A Managed-Care In-Network plan with the option to choose an Out-of-Network physician, subject to a deductible and 20% coinsurance. Must live within Maryland service area of plan.	Lower Premium	Must choose a Primary Care Physician. Referrals required for most services to receive full In-Network benefits.	In-Network: $5 Primary Care $10 Specialist Care	Out-of-Network: May choose any physician at time of service, but such service is subject to a deductible and 20% coinsurance.
HMO • Blue Choice • Kaiser • Optimum Choice	Must choose a Primary Care Physician and receive all services from this physician. Your Primary Care Physician will refer you for Specialist Care if necessary. Must live within Maryland service area.	Lowest Premium	Primary Care Physician must pre-authorize all care.	$5 Primary Care $10 Specialist Care	No coverage for Out-of-Network services, except for medical emergencies.

MEDICAL

MEDICAL PLAN HIGHLIGHTS

VISION BENEFITS AVAILABLE ONLY THROUGH YOUR MEDICAL PLAN

If you want to have vision benefits in Year 2004, you must be enrolled in a medical plan in Year 2004. If you are not enrolled in a medical plan in Year 2004, you will not have vision benefits.

DENTAL BENEFITS AVAILABLE ONLY THROUGH DENTAL PLANS

If you want any dental benefits in Year 2004, you MUST BE ENROLLED in one of the three available dental plans. If you are not enrolled in one of the three available dental plans for Year 2004, you will have no dental benefits.

PRESCRIPTION BENEFITS AVAILABLE ONLY THROUGH THE PRESCRIPTION DRUG PLAN

Please refer to pages 20-24.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Please refer to pages 36-41.

How to Receive Medical Plan Benefits

Once enrolled in the plan of your choice, you will receive identification cards in the mail. Take these cards with you every time you receive medical services. Depending on what type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary. It is your responsibility to select the benefits plan that best suits your service and financial needs.

There are no pre-existing condition clauses for any of the medical plans, but there are other exclusions. Please contact the medical plans for further information on coverage exclusions, limitations, determination of medical necessity, preauthorization requirements, etc.

NOTE: All claims must be submitted within one year of the date of service. This includes resubmission of rejected claims.

Preferred Provider Organization (PPO): This plan allows you to choose any doctor you want at the time of service. Simply present your card to the provider. If your doctor is a participating physician in the PPO network, you will pay a copayment at the time of service. The copayment will be $15 for a Primary Care Physician, $20 for a Specialist.

If the doctor is not a participating PPO physician, you may have to pay the entire fee at the time of service and submit a claim for consideration. This amount will be applied toward your deductible ($250/individual, 500/family). After you have reached your annual deductible, your PPO plan will pay 80% of the plan's allowed amount. You are responsible for the remaining 20% as well as any fees above the plan's allowed amount.

MEDICAL

If you receive services from a non-participating physician, you may end up paying more than the plan's allowed amount. For example, if you receive services from a non-participating provider who charges $1500 for service, but the plan only allows $1000 for that service, you are responsible for the difference.

Actual Charges:	**$1500**	**Amount non-participating provider charges for service**
	-$ 500	**(Plan Reduction) Member liable for this cost**
What your plan covers:	**$1000**	**Plan's allowed amount for this service**
	-$ 250	**Annual Individual Deductible paid by you for using a non-participating provider**
	$ 750	**Plan pays 80% of allowed charges**
	-$ 150	**20% coinsurance paid by you (this is also the amount applied against your out-of-pocket annual maximum)**
	$ 600	**Amount plan will pay after all deductibles and copayments have been paid**
What you owe to non-participating provider:	**$ 900**	

Point-of-Service Plan (POS): This plan is a Managed Care or Health Maintenance Organization (HMO) type plan for In-Network benefits, with the option to choose Out-of-Network services without referral from your Primary Care Physician. You must choose a Primary Care Physician for all In-Network Services. When you use your In-Network benefits, receiving care from your Primary Care Physician, you only pay the required copayment at the time of service. The copayments are the same as those for an HMO -- $5 for Primary Care and $10 for Specialists.

You also may choose to receive treatment Out-of-Network without getting preauthorization from your Primary Care Physician. This is called "self-referral." This POS option gives you the freedom to choose your own provider, subject to a deductible and 20% coinsurance. Simply present your card to the provider. You will have to pay the bill at the time of service, but it will be applied toward your Out-of-Network deductible ($250/individual, $500/family). After your deductible has been met for Out-of-Network services, the plan will pay 80% of the plan's allowed amount for the services. As in the PPO, you pay the remaining 20% to the provider as well as any fees above the plan's allowed amount.

Health Maintenance Organization (HMO): This plan offers the lowest premiums and copayments of the three types of medical plans. If you enroll in this plan, you must choose a Primary Care Physician. Choose carefully, because you will receive all of your medical services from this provider. When you receive services In-Network from your Primary Care Physician, you will pay a $5 copayment. If your Primary Care Physician and plan authorize care from a Specialist, your copayment will be $10.

Not all participating physicians are listed in books provided by the plans. Please call the plan to find out if that physician participates in any of the plans offered. Do not rely on the physician's office for current information. Please see the back of this booklet for Plan Phone Numbers and website information.

NOTE: The State cannot guarantee the continued participation of a particular provider in any of the benefit plans. Providers and the plan have the ability to terminate their association. If your plan physician chooses to discontinue participation in the plan, is terminated from the plan, or has chosen to close their panel to new patients, you will not be allowed to change your plan until Open Enrollment. You should pick a new primary care provider for treatment until you are able to change plans during Open Enrollment.

MEDICAL

NOTE: Even if a hospital or Emergency Room participates in a plan network, not all physicians in a hospital or Emergency Room may participate with the plan. Call the plan before obtaining services to determine if physicians participate in the plan. If lab services are ordered by a physician, call the plan to confirm that the lab participates in the plan.

Questions?

There are so many different types of plans. How do I know which one is best for me or for my family?

You can make the best choice for a medical plan by considering a number of factors:

- **How much do I want to pay in premiums?**
  PPO plans are the most expensive, followed by POS plans, and HMO plans are generally the least expensive. Be aware that POS and HMO plans somewhat limit your choice of providers, so you must balance your need to choose a particular provider against the premium cost of a particular plan.
- **How important is it to me to be able to choose my own provider?**
  PPO plans allow the widest choice, followed by POS plans, and HMO plans limit your choice to a primary care physician who participates in the network.
- **What will my out-of-pocket costs be? Are there copayments? Do I have to pay a deductible with a certain plan?**
  PPO plans have the highest copayments, while POS and HMO plans have the lowest when services are obtained in-network. If you go out-of-network in the PPO or POS plan, your services are subject to a deductible and coinsurance. See the medical benefit chart for more information.
- **What providers participate in the plan's network?**
  You must call the medical plan for this information because providers don't always know the correct information. Even if your provider says that he or she participates in a particular network, you still must call the medical plan to confirm participation. Providers or the plan may choose to terminate their association.
- **What, if any, coverage is available if I choose a provider who does not participate in the network?**
  HMO plans cover nothing if you go out-of-network. PPO and POS plans offer some coverage, but your cost will be higher, including deductibles and coinsurance payments. See the medical benefit chart for more information.
- **How do I obtain care from a specialist?**
  PPO plans allow you to go directly to a specialist without preauthorization. POS plans, when using in-network services, require preauthorization from the plan before you see a specialist. HMO plans always require preauthorization before you see a specialist.
- **Do I need to file claim forms?**
  When you use any of the plans in-network, you won't have to file claim forms. In HMO plans, you never have to file claim forms. Out-of-network care or care received from a non-participating provider will require submission of claim forms. Call your plan for more information on how to obtain claim forms.
- **I'm not satisfied with my plan's decision to deny coverage for a benefit and my plan's payment. How do I appeal my plan's decision?**
  You have the right to appeal a plan's decision or payment through the plan's appeal process first. Please contact the plan on their appeal procedures. If you have exhausted the plan's appeal process, please see the "Benefit Appeal Process" section of this booklet, for information on appeals to the State Benefits Review Committee. This appeals process includes any appeal on coverage for mandated benefits.

Choosing a medical plan is a very personal choice. Please read the medical section thoroughly so that you are aware of the benefits and limitations of each type of plan. Being informed will help you choose the plan most suited to your needs and your family's needs. If you have further questions concerning coverage for particular treatments or In- or Out-of-Network coverage, please contact your plan at the phone number listed on the back cover of this book.

MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Deductibles Individual Family	None None	$250 $500	None None	$250 $500	None None
Out of Pocket Maximums* Individual Family	None	$3,000 Individual $6,000 Family	None	$3,000 Individual $6,000 Family	None
*Any fees above the plans allowed amount are not counted toward the Out of Pocket Maximum.					
Lifetime Maximums	The Lifetime Maximum per each covered individual {i.e. employee or retiree, spouse, child(ren)} is $2 million per lifetime.				
Physicians Primary Care Office Visit	100% after $15 copay	80% after deductible	100% after $5 copay	80% after deductible	100% after $5 copay
Specialist Office Visit	100% after $20 copay	80% after deductible	100% after $10 copay	80% after deductible	100% after $10 copay
Routine Annual GYN Exam	100% after $15 copay	80% after deductible	100% after $5 copay when preauthorized by Plan	80% after deductible	100% after $5 copay when preauthorized by Plan
Inpatient Care Requires Preauthorization	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Outpatient Surgery May require Preauthorization	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Hospitalization	100% for 365 days	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan
Surgery (Subject to pre-authorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

MEDICAL

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Anesthesia Services	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Maternity Benefits	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact plan to confirm if your hospital's Neonatal Unit participates in the Plan. If the Neonatal Unit and its physician do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The plan will only pay these providers under the "Out-of-Network Coverage" benefits. (Includes pre/post natal care and delivery. 2nd opinion required for non-emergency C-section)					
Newborn Care	100%	80% after deductible	100% for enrolled newborn when preauthorized by Plan	80% after deductible	100% for enrolled newborn when preauthorized by Plan
Contact plan to confirm if your hospital's Neonatal Unit participates in the Plan. If the Neonatal Unit and its physician do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The plan will only pay these providers under the "Out-of-Network Coverage" benefits. (Must be enrolled within 60 days of birth with Employee Benefits Division. See Agency Benefits Coordinator)					
Diagnostic Lab & X-ray	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Chiropractic Services	100% after $20 copay	80% after deductible	100 % when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Acupuncture Services for Chronic Pain Management	100% after $20 copay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Whole Blood Charges	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Medical Supplies	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Includes but not limited to:surgical dressings; casts; splints; syringes; dressings for cancer, burns or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment & machines; and all diabetic supplies as mandated by Maryland law) **Contact Plan for details on covered items.**					

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Organ Transplants					
• Per calendar year for cornea, kidney, and bone marrow	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
• Per 365 days up to $1 million per heart, heart-lung, single or double lung, liver, and pancreas	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Durable Medical Equipment	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact Plan for further details on covered items.					
Chemo-therapy/ Radiation	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan Benefit
Contact Plan for further details.					
Therapies	100% after $20 copay Initial Evaluation & Re-evaluation	80% after deductible	100% after $10 copay when preauthorized by Plan	80% after deductible	100% after $10 copay when preauthorized by Plan
• Occupational Therapy (up to 100 visits per year when combined with Physical Therapy)					
• Physical Therapy (up to 100 visits per year when combined with Occupational Therapy)					
• Speech Therapy (up to 50 visits per year)					
Private Duty Nursing (Must be preauthorized by all plans)	100%	80%after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact Plan for further details.					

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Second Opinion (Surgical)	100%	100%	100%	100%	100% when preauthorized by Plan, or **when required by Plan**
Ambulance Services	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies
Urgent Care Centers	$10 copay	$10 copay 80% after deductible	$10 copay	$10 copay 80% after deductible	$10 copay
Emergency Room Services - Inside and Outside of Service Area	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment

NOTE: Emergency Services or Medical Emergency: Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Contact Plan for further details.

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

MEDICAL

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Mental Health/ Substance Abuse **NOTE: See Mental Health/Substance Abuse section of this booklet for further information about using APS. (Not applicable to HMO plans.)**	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	100% for in-patient care up to 365 days when preauthorized by Plan. 80% for out-patient care, visits 1-5; 65% for out-patient care, visits 6-30; 50% for out-patient care, visits 30+ per calendar year.
Extended Care Facility	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(For up to 180 days per calendar year of skilled nursing care when medically necessary)					
Hospice	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Home Health Care	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(For up to 120 days per calendar year)					
Mammo-graphy	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Certain age restrictions and timeframes apply for screening mammograms. Coverage for screening mammograms varies by age. Call your plan.)					
Pap Test	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

MEDICAL

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Family Planning & Fertility Testing	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Including: sperm count hysterosalpingography, endometrial biopsy, IUD insertion, vasectomy, tubal ligation. Only 1 reversal covered per lifetime)					
In Vitro Fertilization (IVF) and Artificial Insemination **NOTE: Contact your plan for further details on Preauthorization Requirements:** Member must be married. Not covered for surrogate motherhood.	100% for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	80% after deductible for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	100% when preauthorized by Plan for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	80% after deductible for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	100% when preauthorized by Plan for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime
Norplant Surgery Only	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a married (recognized by the laws of Maryland) woman if she was infertile:

- throughout the most recent two(2) years of marriage to the same man; or
- her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or
- male infertility is the documented diagnostic cause.

The patient's oocytes must be fertilized with the patient's spouse's sperm. In-Vitro Fertilization and Artificial Insemination are covered for a maximum of 3 attempts per procedure.

THIS IS ONLY A SUMMARY. CONTACT YOUR PLAN FOR FURTHER DETAILS ON PREAUTHORIZATION REQUIREMENTS.

- The 3 IVF attempts per live birth will not exceed a maximum expense of $100,000 per lifetime.
- The Artificial Insemination attempts must be taken, when medically appropriate, before IVF attempts will be covered.

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Well-Baby Care Under 1 year: 6 visits; 1-2 years: 2 visits; 2 years +: 1 visit per yr	100% after $15 copay per visit, to age 12	80% after deductible per visit, to age 12	100% after $5 copay per visit, to age 12, when preauthorized by Plan	NOT COVERED	100% after $5 copay per visit, to age 12, when preauthorized by Plan
Contact plan for further details on time eligibility for visits.					
Immunizations	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(As recommended by the American Medical Association and the American Academy of Pediatrics, including immunizations required for participation in school athletics; including Lyme Disease.) **(Contact your plan for further details)**					
Physical Exams - 1 every 3 years for all members and their dependents age 13 and older	100% after $15 copay	80% after deductible	100% after $5 copay if preauthorized by Plan	NOT COVERED	100% after $5 copay for exam when preauthorized by Plan
Contact plan for further details on time eligibility for exams.					
Hearing Examinations and Hearing Aids, including mandated benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective January 1, 2002, including hearing aids per each impaired ear for minor children.	100% after $15 copay for exam. 100% for Basic Model hearing aid. 1 exam and hearing aid every 3 years for each employee and dependent.	80% after deductible	100% after $5 copay for exam when preauthorized by Plan. 100% for Basic Model hearing aid. 1 exam and hearing aid every 3 years for each employee and dependent.	NOT COVERED, except for hearing aids as mandated for minor children (ages 0-18) as mandated by Maryland law effective January 1, 2002.	100% after $5 copay for exam when preauthorized by Plan. 100% for Basic Model hearing aid. 1 exam and hearing aid every 3 years for each employee and dependent.

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

MEDICAL

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Allergy Testing	100% after $15 copay	80% after deductible	100% after $5 copay when preauthorized by Plan	80% after deductible	100% after $5 copay when preauthorized by Plan
Diabetic Nutritional Counseling as mandated by Maryland law	100% after $15 copay	80% after deductible	100% after $5 copay when preauthorized by Plan	80% after deductible	100% after $5 copay when preauthorized by Plan
Prescription Drugs	NOT COVERED UNDER MEDICAL PLAN				
Dental Services	NOT COVERED UNDER MEDICAL PLAN				
Vision - MEDICAL					
Any services that deal with the medical health of the eye	100% after $15 copay (primary care physician) or $20 copay (specialist)	80% after deductible	100% after $5 copay or $10 copay (specialist) when preauthorized by Plan	80% after deductible	100% after $5 copay or $10 copay (specialist) when preauthorized by Plan

Vision - ROUTINE

(Provided by your health plan) – Any services that deal with correcting vision.

Plan Pays Up To: Exam - $45 (Available once every year)

Prescription Lenses (per pair) - (Available once every year)

- Single Vision - $ 28.80
- Bifocal, single - $ 48.60
- Bifocal, Double - $ 88.20
- Trifocal - $ 70.20

Aphakic: Glass - $ 54.00
Plastic - $126.00
Aspheric - $162.00

Frames - $45 (Available once every year)

Contacts (per pair, **in lieu of frames and lenses).** Available once every year.

- Medically Necessary - $201.60
- Cosmetic - $50.40

Vision benefits are only available through your health plan. You may obtain vision services from any licensed vision provider, whether in your health plan or not. To obtain vision benefits, you must contact your medical plan for more information. Vision benefits are available once every year.

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

MEDICAL

General Limitations and Exclusions

This is a general summary of limitations and exclusions. This list is subject to change at any time. Please call the plan for further information.

The State does not cover services and supplies:

- for services not deemed medically necessary by the Plan,
- not prescribed, done, or guided by eligible practitioners,
- when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons,
- provided through a dental or medical department of an employer, a mutual benefit association, a labor union, a trust, or a similar entity,
- for personal hygiene, cosmetic and convenience items, air conditioners, humidifiers, exercise equipment, elevators or ramps, even if recommended or prescribed by a physician,
- for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services,
- for separate billings for services or supplies furnished by an employee or a hospital or practitioner which are normally included in such hospital's or practitioner's charges and billed for by them,
- provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner,
- for treatment of a patient who is discharged from a hospital, facility, or institution and readmitted within 14 days after their effective date when such discharge and readmission was for the purpose of qualifying for coverage under this benefit plan,
- for court-ordered examinations, care, or confinement, unless otherwise medically necessary,
- rendered or available under any Workers Compensation or occupational disease, or employer's liability law, or any other similar law, even if the member fails to claim benefits,
- that are excluded from coverage under Medicare,
- to the extent the services and supplies are provided under Medicare,
- for the treatment of any injury, illness, or medical condition that is not medically necessary,
- for illnesses resulting from an act of war,
- for any illness due to a criminal act if the member is the principal or aids in its commission,
- for cosmetic surgery, or cosmetic surgery performed to treat a psychiatric or emotional condition except as may otherwise be specifically provided in this benefit plan,
- for sex changes,
- primarily for custodial care or rest cures,
- that are provided for care of any kind in connection with habilitation,
- cardiac rehabilitation when not done because of single-lung, double-lung, heart, or heart-lung transplant,
- for conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for hospital stays for environmental change,
- for milieu care or In-Vivo therapy,
- for non-medical or non-surgical self-care or self-help training,
- for treatment of obesity (except morbid obesity), weight reduction, or dietary control,
- for routine podiatry care unrelated to diabetes mellitus and peripheral vascular disease and diabetic neuropathy,
- for inpatient private duty nursing services,
- diagnostic services for:
  - the interpretation of clinical lab tests, such as blood counts, when practitioner's service is only administrative
  - fluoroscopy without films
  - care of teeth
  - tests not ordered by a practitioner
  - research tests
  - screening tests when there are no symptoms or patient complaint except for routine examinations except as mandated by law
  - pre-marital exams
- a transplant or procurement done outside the continental U.S.
- covered services if there are research funds to pay for the covered services,
- services or supplies to the recipient or companion(s) if no payment is required,
- expenses incurred for the location of a suitable donor, e.g. the National Bone Registry.

MEDICAL

Special Information on HMOs:
Some State employees may be interested in knowing an HMO's corporate status before choosing a medical plan. The following is a chart illustrating for-profit and not-for-profit HMOs in the 2004 State of Maryland benefits program, along with their payment methods for primary care physicians (PCP) and specialists. This chart is provided for your information only, and is not a recommendation for any specific type of HMO. Please call your plan for more information.

HMO	Corporate Status	Payment Method(s) for Physicians
Blue Choice	For-Profit	Discounted Fee-for-Service
Kaiser Permanente	Not-for-Profit	Salaried Employees
Optimum Choice (MAMSI)	For-Profit	PCPs: Capitation based upon age and sex of PCP's patients Specialists: Negotiated Fee Maximums

**Health Services Cost Review Commission.

HMO Report Cards: The Maryland Health Care Commission (MHCC) develops an annual "HMO Report Card." This publication entitled "Comparing the Quality of Maryland HMO's, A Guide for Consumers," is available free at all public libraries, and on the Internet at www.mhcc.state.md.us. During Open Enrollment: MHCC also creates a special edition of the HMO guide specifically for employees of the State of Maryland. You should have received a copy of that booklet, called "Comparing the Quality of Maryland HMO's, A Guide for State Employees," with this booklet and other materials describing the employee benefits for 2004. Please see your Agency Benefits Coordinator to request a copy of the HMO guide.

PRESCRIPTION

PRESCRIPTION PLAN

General Description of Coverage

Prescription plan coverage is available to all individuals and their dependents who are eligible for health benefits with the State. The State's prescription plan is administered by AdvancePCS, Inc. The prescription plan covers the cost of most approved prescription drugs, subject to nominal copayments. These copayments are determined by whether the drug is on the AdvancePCS formulary and whether the drug is a brand-name or generic.

Certain drugs are not covered under this plan.

Formulary: A formulary is a selected list of drugs. AdvancePCS has a panel of physicians and pharmacists that meets regularly to identify and review prescription drugs that provide the highest therapeutic and economic value. By choosing drugs on this list, your physician helps keep the cost of prescription drugs affordable. Formulary drugs are subject to change at any time. Your physician may contact AdvancePCS to obtain information on formulary drugs.

Brand-name drug: A brand-name drug is any approved drug a particular pharmaceutical company has the exclusive right to produce and sell. Over time, companies can lose the patents on particular drugs, opening up the market to generic equivalents. Generic drug equivalents may become available at any time.

Generic drug: A generic drug is made with the same active ingredient as found in the brand-name product. All generics must meet the same manufacturing and testing standards as the brand-name drug. If a generic drug is available, the State plan only covers up to the cost of the generic.

NOTE: The State prescription plan only covers up to the cost of a generic drug, when the generic is available. If you purchase a brand-name drug when a generic drug is available, even if it is prescribed by your physician, you must pay the difference in price between the brand-name and the generic, as well as the standard copayment amount. The plan does not pass judgment on a physician's determination as to the appropriate medication for treatment, but the plan does have limitations as to the types and amounts of reimbursement available.

How to Receive Prescription Plan Benefits

Please take your AdvancePCS card with you when you get your prescriptions filled. If you are enrolling in the prescription plan for the first time, AdvancePCS will issue you a maximum of two cards per family. An additional card may be ordered for students residing out of state, by calling AdvancePCS. Any stolen cards must be reported to AdvancePCS immediately. All cards are issued with the name of the employee or retiree embossed on the card. Dependent names are not listed on the card.

If you choose a formulary drug, you will pay a $5 copayment when you purchase the drug. If your physician has prescribed a drug that is not on the AdvancePCS formulary, the copayment will be $10. If you purchase a brand-name drug when a generic drug is available, you must pay the difference between the brand-name and generic drug, in addition to the standard copayment amount of $5 or $10. AdvancePCS is also offering State members a list of preferred Performance drugs (see the following section), which have $3.00 copayments. **Preferred Performance drugs, Formulary drugs, and Non-formulary drugs are subject to change at anytime.**

Participating Pharmacies: If you use a pharmacy that participates in the AdvancePCS network, you only need to pay the necessary copayment at the time of service. More than 900 pharmacies in the State of Maryland participate in the AdvancePCS network. AdvancePCS also has a nationwide network of participating pharmacies. If you are traveling out-of-state or just want to know if a particular pharmacy participates in the AdvancePCS network, contact AdvancePCS at the phone number listed on the back cover of this book.
If you visit a pharmacy that is not a member of the AdvancePCS network, you must pay the pharmacist the entire cost of your prescription drug and submit a paper claim form to AdvancePCS for reimbursement. You will be reimbursed the amount that the State would have paid to an AdvancePCS pharmacy minus a $12.50 copayment. This amount may be less than your out-of-pocket cost. **You have one year from the date you have a prescription filled to submit a paper claim to AdvancePCS.**

If you must obtain a prescription without an AdvancePCS Enrollment Card, you will need to submit an AdvancePCS claim form for reimbursement. Please send your completed claim form and receipt to: Employee Benefits Division, 301 W. Preston St., Room 510, Baltimore, MD 21201 Attn: AdvancePCS Coordinator. All claims must be submitted within one year of the date of service.

Preferred Performance Drugs: Certain drugs, which are called "Preferred Performance drugs," are available for a $3 copayment. Please review this listing of Preferred Performance drugs with your physician. **Preferred Performance Drugs are subject to change at anytime.** Contact AdvancePCS at the number listed on the back cover for the most current information on "Preferred Performance Drugs."

Maintenance Drugs: Some prescription drugs may be available in 90- or in 100-day supplies, depending on State law or AdvancePCS policy. Please contact AdvancePCS for more information on drugs that may be prescribed in 100-day supplies. Please see your physician for more information on drugs that may be prescribed in 90-day supplies under State law.

Questions

How much will I have to pay?

1. If you receive a formulary drug, you pay $5.
2. If you receive a non-formulary drug even though a formulary drug is available, you pay $10.
3. If you purchase a brand-name drug when a generic is available, you must pay the difference between the brand-name and generic drug, and the standard copayment amount of $5 or $10.
4. If you purchase a preferred performance drug, your copayment is $3.

What happens when I use a non-participating pharmacy?

You pay the total cost to your pharmacy and submit a paper claim to AdvancePCS. You are reimbursed for the balance after your portion of the cost is determined. Your portion of the total cost is a $12.50 copayment plus the difference between the total charges and what the State would pay a participating pharmacy. If you purchase a brand-name drug when a generic is available, you are also responsible for the difference in cost between the brand-name and generic drug. Contact AdvancePCS for claim forms. All claims must be submitted within one year of the date of purchase. Any claims more than one year old will not be reimbursed.

My pharmacist just told me it is too soon to refill my prescription. Why?

All of your drug plan prescriptions are screened by the AdvancePCS computerized concurrent drug utilization review monitoring system called QUANTUM Alert. The QUANTUM Alert program automatically calculates how long it would take you to use up to 75% of your prescription. If you attempt to refill your prescription before the calculated date, your refill will not be honored by AdvancePCS.

PRESCRIPTION

NOTE: There are some circumstances when you will be allowed to obtain an early refill or advance supply of a drug, such as when you are going on vacation, for a dosage change during the course of treatment, or for lost or destroyed medication. You or your physician must contact AdvancePCS to obtain prior authorization for an early refill or advance supply of a prescription. Your pharmacist can also call the AdvancePCS Help Desk to assist you in obtaining an early refill or advance supply. See phone numbers on the back cover of this book.

When is prior authorization needed?

Certain drugs require prior authorization (called Managed Access) and are subject to certain constraints before coverage will be provided. Drugs requiring prior authorization include: Retin- A for individuals age 26 and older, growth hormones, dexedrine, Adderall, and phenylbutazone. You must contact AdvancePCS to obtain prior authorization on these drugs. **The list of drugs requiring prior authorization is subject to change at any time.** See phone numbers on the back cover of this book.

Other Questions?

If you have any questions about coverage, exclusions, or limitations, or need to report stolen or missing cards, please contact AdvancePCS at the phone number listed on the back cover of this book.

The chart on page 24 gives examples of the types of drugs that are covered and those that are excluded. This is not a comprehensive list and is subject to change at any time. If you have any questions about a particular drug, please contact AdvancePCS at the phone number listed on the back cover.

Preferred Performance Drugs – Subject to change at any time

Cardiovascular

Ace Inhibitors
- Captopril
- Enalopril
- • Accupril®/Accuretic™
- • Altace
- Lisinopril

Angiotensin II Receptor Blockers
- • Avapro®/Avalide®
- • Cozaar®/Hyzaar®

Beta Blockers
- Atenolol
- • Toprol-XL
- Metoprolol
- Propranolol

Calcium Channel Blockers
- Diltiazem Ext-rel[1]
- Verapamil Ext-rel[2]
- • Nifedipine Ext-Rel[6]
- • Norvasc®

HMG Co-A Reductase Inhibitors
- • Lipitor®
- • Pravachol®

Depression

SSRIs
- • Celexa™
- Fluoxetine
- • Paxil®/Paxil CR™
- • Zoloft

Other Antidepressants
- Bupropion
- • Effexor®/Effexor XR®
- • Remeron®/Remeron SolTabs®
- • Wellbutrin SR®

Diabetes

Biguanides/Combination Product
- Metformin
- • Glucovance®

Sulfonylureas
- Glipizide
- Glyburide/Glyburide micronized
- • Amaryl®
- • Glucotrol XL®

Thiazolidinediones
- • Actos®
- • Avandia®

Insulin Product Lines
- • Humalog®/Humulin®
- • Lantus®
- • Novolin®/Novolog®

Gastrointestinal Agents

H2-Antagonists
- Cimetidine
- Ranitidine tabs

Proton Pump Inhibitors
- • Aciphex™
- • Nexium™
- • Prilosec®

Infection Agents

Antimicrobials

Cephalosporins
- Ceflacor
- Cephalexin
- • Cedax®
- • Omnicef®

Macrolides
- Erythromycins[3]
- • Blaxin®/Biaxin® XL
- • Zithromax®

PRESCRIPTION ■

Preferred Performance Drugs *(continued)* – Subject to change at any time

Penicillins
- Amoxicillin
- Dicloxacillen
- Penicillin VK
- • Augmentin®

Fluoroquinolones
- • Avelox®
- • Cipro®
- • Levaquin

Tetracyclines
- Doxycycline hyclate
- Minocycline
- Tetracycline

Miscellaneous
- Metronidazole
- Sulfamethoxazole/trimethoprin

Antifungals

Onychomycosis
- • Lamisil®

Antivirals

Herpes
- Acyclovir
- • Valtrex®

Low Molecular Weight Heparins
- • Lovenox®

Migraine
Triptans
- • Imitrex®
- • Maxalt®/Maxalt-MLT™
- • Zomig®/Zomig-ZMT™

Opthalmic
Antimicrobials
- Polymycin B/Trimethoprim
- Tobramycin
- • Ocuflox®

Glaucoma

Beta Blockers
- Timolol Maleate solution
- • Betimol®

Alpha Agonists
- • Alphagan®/Alphagan P®

Prostaglandins/Prostamides
- • Lumigan™
- • Xalatan®

Osteoarthritis
NSAIDs
- Ibuprofen
- Indomethacin
- Naproxen
- Naproxen Sodium
- Sulindac

COX-2 Inhibitors
- • Celebrex®
- • Vioxx®

Pain
Analgesics - Moderate to Severe Pain
- Morphine ext-rel
- • OxyContin®

Respiratory
Allergy

Antihistamines - Nasal
- • Astelin®

Antihistamines - Nonsedating
- • Allegra®/Allegra-D®
- • Clarinex®
- • Claritin®/Claritin-D®

Corticosteroids - Nasal
- • Flonase®
- • Nasacort®/Nasacort®AQ
- • Nasonex®
- • Rhinocort®/Rhinocort® Aqua™

Asthma

Beta Agonist Inhalers
- Albuterol
- • Serevent®/Severent Diskus®

Corticosteroid Inhalers
- • Flovent®/Flovent® Rotadisk®
- • Azmacort®
- • Pulmicort Turbuhaler

Corticosteroid/Beta Agonist Combinations
- • Advair™ Diskus®

Leukotriene Modifiers
- • Accolate®
- • Singulair

Thyroid Replacement
- • Levoxyl®
- • Synthroid®

Urologic Disorders
Benign Prostatic Hypertrophy
- Doxazosin
- Terazosin

Urinary Incontinence
- Oxybutynin
- • Detrol®/Detrol® LA

Women's Health
Osteoporosis

Hormone Replacement - Oral
- Estradiol
- Estropipate
- • Cenestin®
- • Femhrt™
- • Premarin®
- • Premphase®
- • Prempro™

Hormone Replacement - Transdermal Estradiol[4]
- • Esclim™
- • Estraderm®
- • Estradiol®[7]
- • Vivelle®/Vivelle-Dot™

Selective Estrogen Receptor Modulators
- • Evista®

Bisphosphonates
- • Fosomax®

Oral Contaceptives

Monophasic
- • Lo-Ovral®
- • Levora®
- • Loestrin/Loestrin Fe
- • Low-Orgestrel
- • Mircette®
- • Modicon®
- • Ortho-Cept®
- • Ortho-Cyclen®
- • Ortho-Evra-transdermal™
- • Ortho-Novuum®[5]
- • Zovia®
- • Yasmin®

Triphasic
- • Estrostep® Fe
- • Ortho-Novuum® 7/7/7
- • Ortho-Tri-Cylen®
- • Tri-Norinyl®
- • Trivora®
- • Cyclessa™

Progestin-only
- • Ortho Micronor®

Miscellaenous
- • Nuva Ring®

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1 Generic equivalents of Cardizem® CD or Dilacor XR®

2 Generic equivalent of Calan® SR and Isoptin® SR

3 Generic equivalent of E.E.S.®, E-Mycin®, ERYC®, Erythrocin®, and Pediazole®

4 Generic equivalents of Climara®

5 Includes Ortho-Novum® 1/35, 1/50 and 10/11

6 Generic equivalents of Adalat® CC or Procardia XL®

7 Generic equivalents of Climara®

PRESCRIPTION

■

Standard Prescription Plan Benefits Chart

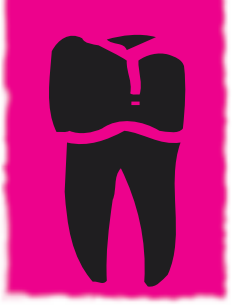
Subject to change at any time

Covered Drugs	Excluded Drugs
Insulin, rabies vaccine, ceredase, and most legend drugs prescribed on an outpatient basis, including: Allergy Serum; Compounded medication of which at least one ingredient is a legend drug; Lupron; Oral contraceptives, Norplant, Depo-Provera; Ritalin; Tretinoin, all dosage forms (e.g., Retin-A) for individuals through the age of 25; Rocaltrol.; and Pre-Natal Vitamins.	Anorectics (any drug used for the purpose of weight loss); Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order; Charges for administration or injection of any drug; Contraceptive devices; DESI drugs (drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness); Dietary supplements; Drugs labeled "Caution-limited by federal law to investigational use or experimental drugs," even though a charge is made to the individual; Immunization agents, biological sera, blood, or blood plasma; Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent home, nursing home, veterans hospital or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; Minoxidil (Rogaine); Non-legend drugs other than insulin and rabies vaccines and ceredase; Prescriptions that an eligible person is entitled to receive without charge under Workers' Compensation Law; Therapeutic devices or appliances, including needles, syringes, support garments, and other non-medical substances, regardless of intended use; or, Vitamins, singly or in combination, including fluoride (exception: Rocaltrol and Pre-Natal Vitamins); Anti-wrinkle agents (e.g., Renova, Retin-A for individuals 26 years of age or older); Dexedrine; except through Prior Authorization; Growth hormones, except through Prior Authorization.

NOTE: Allergy Serum is covered through the AdvancePCS Prescription Drug Plan. Claims for reimbursement of Allergy Serum should be submitted to AdvancePCS. Claims for reimbursement of allergy testing and physician services associated with allergy injections should be submitted to your health plan.

NOTE: The Prescription Drug Plan does not coordinate benefits with any other plan.

NOTE: AdvancePCS will reimburse a claim for Meningitus Vaccines provided according to the Maryland law, for students attending a university in Maryland.. Please submit your AdvancePCS claim and receipt to the AdvancePCS Coordinator at the Employee Benefits Division. Any associated physician bills should be submitted to your health plan.



DENTAL PLAN

General Description of Coverage

Dental coverage is available to all individuals who are eligible for health benefits with the State.

You must be enrolled in one of the three dental plans offered if you want to have dental benefits: Dental Benefit Providers DHMO, United Concordia DHMO, or United Concordia DPOS.

If you are not enrolled in one of the three available dental plans for Year 2002, you will not have dental benefits in Year 2004. Dental benefits are not included in any of the medical plans in Year 2004.

NOTE: You have one year from the date you receive a dental service to file a claim.

NOTE: Contact your dental plan to authorize a change to your PCP dentist. After confirmed, your new cards will be sent to your home address.

NOTE: The State cannot guarantee the continued participation of a particular provider in any of the benefit plans. If your plan dentist chooses to discontinue participation in the plan, is terminated from the plan, or chooses to close their practice to new patients, you will not be allowed to change your plan or withdraw from the plan until Open Enrollment. You must contact your dental plan to select another provider.

How to Receive Dental Plan Benefits

You must select a Primary Dental Office (PDO) from your selected dental plan's network of participating dentists when you enroll. You may obtain a Primary Dental Office Selection Form from your Agency Benefits Coordinator or by calling the dental plan. You are free to change your primary provider site selection at any time. Remember to verify provider participation before seeking care by calling your dental plan. Also, before you receive any services, be sure to consult the Schedule of Benefits for the type of dental plan you have chosen to ensure that you have anticipated all out-of-pocket costs and liabilities associated with a particular type of treatment.

If you reside in an area that does not have a plan network of dentists or if you are not satisfied with the plan network, please contact the dental plan to determine other options. Please note that the POS plan does provide out-of-network benefits for the use of non-network dentists. In addition, you may request that the plan evaluate the dentist of your choice for inclusion in the network. However, there is no guarantee that a provider of your request will choose to participate in the plan network.

DENTAL

Dental Health Maintenance Organization (DHMO)

How the DHMO Plans Work

There are two Dental HMOs available:
- Dental Benefit Providers (DBP)
- United Concordia (UCC)

The Dental HMOs cover only services from in-network dentists.

The United Concordia DMHO plan offers each family member the option of selecting a different **Primary Dental Office** from the dental network, which will provide, or arrange for, all of their dental care. The Dental Benefits Providers DHMO permits 2 PDOs per family. The selected dentist will provide or arrange for all of the dental care provided for you and your dependents. Preventive and diagnostic dental care is covered in full, while restorative and other major services are offered at a reduced cost. Orthodontic services are available for both adults and children (call the dental plans for details and limitations). There are no claim forms and you are only responsible for copayment amounts which are part of the program design. There are no deductibles and no yearly benefit maximums. A referral is required in order to see a specialist.

You must select a primary dental office regardless of intention to use.

Dental Point-of-Service Plan (POS)

How the POS Program Works

The Dental POS plan is available through United Concordia. This plan offers each family member the option of receiving care at a pre-selected dental network site (the **Primary Dental Office**) or from another dental provider of their choice. If you choose to receive care outside of the Primary Dental Office, benefits are paid at a separate schedule of benefits. All preventive and diagnostic care received from the Primary Dental Office is covered in full while restorative and other major services are offered at a reduced cost. Orthodontic services are available (in-network only) for both adults and children. Call United Concordia for details and limitations. There are no claim forms when you receive care in-network and you are only responsible for copayment amounts which are part of the program design. While there is no maximum benefit for in-network services, there is a maximum benefit of $1,000 per member per calendar year for out-of-network services.

You must select a primary dental office regardless of intention to use.

Copayments

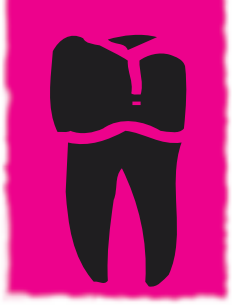
All **preventive and routine diagnostic** services are covered at 100% when services are received from the primary dental office. Review the Schedule of Benefits for each plan for the copayment amounts associated with each type of dental service. Services not listed on Schedule of Benefits are excluded from coverage.

Predetermination of Benefits

There is no general requirement for you or your primary dentist to seek predetermination of benefits before treatment starts. However, you are encouraged to do so for major dental procedures so that you and your dentist will know exactly what will be covered and what your financial liability will be.

Out-of-Area Emergencies

Your selected dental plans will pay up to a maximum of $50, subject to your copayment, for emergency dental services when you are travelling out of the area (more than 50 miles from your dentist's office). In order to receive payment for out-of-area emergency care, you must submit a receipted bill itemizing the charges and services performed. This claim should then be forwarded to your dental plan for processing.



Advantages of the DHMO

When care is received **in-network**, there are:

- No claim forms
- No deductibles
- No charges for Preventive and Diagnostic Services
- No pre-existing condition exclusions, except for orthodontics in progress (see Special Note on Treatment in Progress)
- Coverage for braces for children and adults

THINGS TO REMEMBER

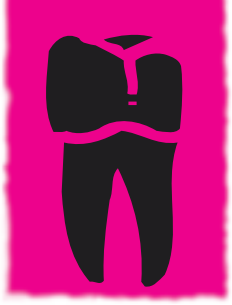
- You can enroll in any of the three available dental plans
- You, or a family member, can change your primary dentist at any time (if no balance exists)
- Copayments are the same, regardless of whether care is rendered by a participating general dentist or a specialist

DHMO only

- Claim submission is necessary for out-of-area emergency care.
- You must obtain a referral from your primary care dental site to see a specialist.
- You must receive services from a participating plan dentist.
- You must contact the plan to designate your PDO. Verify same PDO upon receipt of membership card.

POS only

- Out-of-pocket expenses are higher when services are received out-of-network
- Claim submission is necessary for out-of-network reimbursement and out-of area emergency care
- The out-of-network maximum benefit is $1,000 per member per calendar year
- There are no out-of-network orthodontic benefits
- You must contact the plan to designate your PDO. Verify same PDO upon receipt of membership card.



DENTAL

Questions?

Will every family member get a card?
Every member in any of the dental plans will receive a membership card identifying the dental plan and the name and phone number of the primary dental site.

Do I have to have my dental card with me to receive benefits?

If you are a new employee and need services, you should take your dental card with you to the initial visit. You do not have to have your dental card with you in order to receive care. Dental plan providers receive monthly lists of members registered to their site from the dental plan. Providers in the network also can verify your plan eligibility by calling the dental plan.

Why does my membership card show an In-Network dentist? I do not use an In-Network provider.
All members must choose a primary dental office from the network of the dental plan in which you enroll. However under the United Concordia POS Plan, you have the option of receiving most care from a provider other than your primary dentist. When a decision is made to receive care outside of your primary dental office, benefits are paid in accordance with a separate schedule of benefits, except for excluded services, which are only covered in-network. Additionally you are subject to balance billing for the difference between the plan payment and the provider's charge.

Must family members go to the same dentist?
No. For the United Concordia Dental Plans offered, each family member may select a different participating general dental office. For the Dental Benefits Provider DHMO, up to 2 dentists may be selected per family.

Can I change dentists? How do I change dentists?

All employees of the State of Maryland and their dependents can change dentists at any time, as long as there is no balance owed at the existing provider site. To change dentists, you simply call your dental plan. A representative can assist you with your new selection and can tell you when your selection is effective and expect new cards.

Do I have to fill out claim forms after each routine visit?

For routine visits to your primary dental office, no. Under the United Concordia POS Plan, you must submit claim forms if you are seeking reimbursement for eligible out-of-network services. Under the two DHMO plans, you must submit a claim for out-of-area-emergency care.

Do I have to be referred to a specialist?

You must be referred to a participating specialist by your participating general dentist in order to be eligible for in-network specialist benefits.

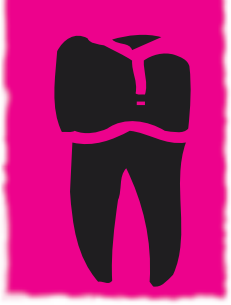
Is there an extra charge for care provided by a specialist?

For covered services, the fee schedule remains the same whether your care was provided by a general dentist or a specialist. There is no coverage for excluded services and you will be required to pay all of your provider's charges. THERE ARE NO OTHER PRE-EXISTING CONDITION LIMITATIONS.

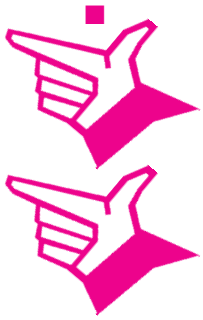
What about orthodontia for adults and children?

Orthodontic benefits are available to all enrolled members, children and adults alike. Orthodontic benefits must be received from an in-network provider in all three of the dental plans offered. There is no out-of-network coverage for orthodontic treatment.

NOTE: Dentists may choose to provide services that are excluded from your State of Maryland benefits. The plan does not pass judgement on a dentist's determination as to the appropriate dental treatment, but the plan will not cover excluded services. You will be responsible for paying all of your provider's charges for non-covered services.



DENTAL



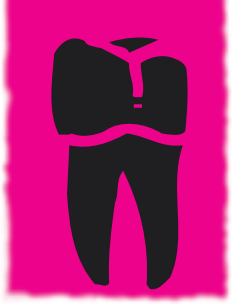
Other Questions?

For more information, call **Dental Benefit Providers** or **United Concordia** at the phone number listed on the back cover of this book.

SPECIAL NOTE ON TREATMENT IN PROGRESS AND ORTHODONTIA: If you switch dental plans as a result of your dental selection for Year 2003, the current dentist is required to complete Treatment in Progress as defined by Maryland law (other than orthodontia) as of December 31, 2003.

If you or a family member has treatment in progress or orthodontia treatment in progress as of December 31, 2003 and you switch dental plans, you must contact the new dental plan prior to January 1, 2004 to discuss possible orthodontia treatment arrangements.

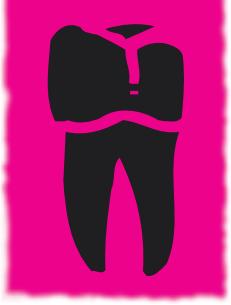
****New employees, who have orthodontic treatment in progress, must contact the dental plan. Orthodontic care may be denied as pre-existing treatment. The dental plan will require the member to pay the orthodontic copayments, even if the member has previously paid copayments to the previous orthodontist.**



DENTAL

Dental Benefits Providers (DBP) DHMO
Schedule of Fees

ADA CODE	PROCEDURE NAME	MEMBER PAYS
DIAGNOSTIC (EXAMS AND X-RAYS)		
120	PERIODIC ORAL EXAMINATION (EVERY 6 MONTHS)	0
140	LTD ORAL EVALUATION - PROBLEM FOCUSED	0
150	COMPREHENSIVE ORAL EVALUATION	0
210	INTRAORAL-COMPLETE SERIES INCLUDING BITEWINGS	0
220	INTRAORAL-PERIAPICAL-FIRST FILM	0
230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	0
240	INTRAORAL-OCCLUSAL FILM	0
270	BITEWING-SINGLE FILM	0
272	BITEWINGS - TWO FILMS	0
273	BITEWINGS - THREE FILMS	0
274	BITEWINGS - FOUR FILMS	0
330	PANORAMIC FILM	0
460	PULP VITALITY TESTS	0
470	DIAGNOSTIC CASTS	0
PREVENTIVE (CLEANINGS & FLUORIDE)		
1110	PROPHYLAXIS ADULT (EVERY 6 MONTHS)	0
1120	PROPHYLAXIS-CHILD (EVERY 6 MONTHS)	0
1201	TOP APPL FLUOR INCL PROPHY-CHILD - AGE 16 (EVERY 6 MONTHS)	0
1203	TOP APPL FLUOR EXCL PROPHY-CHILD - AGE 16 (EVERY 6 MONTHS)	0
1205	TOP APPL FLUOR INCL PROPHY-ADULT - AGE 16 AND OVER (EVERY 6 MONTHS)	0
1351	SEALANT - PER TOOTH (CHILD < AGE 16, LTD TO 4 PERM MOLARS (EVERY 5 YEARS)	0
1510	SPACE MAINTAINER-FIXED UNILATERAL	0
1515	SPACE MAINTAINER-FIXED BILATERAL	0
1520	SPACE MAINTAINER-REMOVABLE UNILATERAL	0
1525	SPACE MAINTAINER-REMOVABLE BILATERAL	0
1550	RECEMENTATION OF SPACE MAINTAINER	0
MINOR RESTORATIVE (FILLINGS)		
2110	AMALGAM-ONE SURFACE PRIMARY	0
2120	AMALGAM-TWO SURFACES PRIMARY	0
2130	AMALGAM-THREE SURFACES PRIMARY	0
2131	AMALGAM-4 OR MORE SURFACES, PRIMARY	0
2140	AMALGAM-ONE SURFACE PERMANENT	0
2150	AMALGAM-TWO SURFACES PERMANENT	0
2160	AMALGAM-THREE SURFACES PERMANENT	0
2161	AMALGAM-FOUR OR MORE SURFACES PERMANENT	0
2330/2385	RESIN-ONE SURFACE ANTERIOR/POSTERIOR	0
2331/2386	RESIN-TWO SURFACES ANTERIOR/POSTERIOR	0
2332/2387	RESIN-THREE SURFACES ANTERIOR/POSTERIOR	0
2335	RESIN-THREE SURFACES OR INVOLVING INCISAL ANGLE - ANTERIOR	0
MAJOR RESTORATIVE (CROWNS)		
2510	INLAY-METALLIC-ONE SURFACE	135
2520	INLAY-METALLIC-TWO SURFACES	150
2530	INLAY-METALLIC-THREE SURFACES	180
2540	ONLAY-METALIC-PER TOOTH (ADDITION TO INLAY)	120
2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	170
2620	INLAY-PORCELAIN/CERAMIC-2 SURFACES	180
2630	INLAY-PORCELAIN/CERAMIC-3 SURFACES	190
2640	ONLAY-PORCELAIN/CERAMIC-PER TOOTH+INLAY	100
2650	INLAY-COMPOSITE/RESIN - 1 SURFACE (LABORATORY PROCESSED)	150
2651	INLAY-COMPOSITE/RESIN - 2 SURFACES (LABORATORY PROCESSED)	160
2652	INLAY-COMPOSITE/RESIN - 3 OR MORE SURFACES (LAB PROCESSED)	170
2710	CROWN-RESIN-LABORATORY	80
2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	230
2750	CROWN-PORCELAIN FUSED TO HI NOBLE METAL	220
2751	CRWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	195
2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	210
MAJOR RESTORATIVE (CROWNS) Continued		
2790	CROWN-FULL CAST HIGH NOBLE METAL	215
2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	195
2792	CROWN-FULL CAST NOBLE METAL	205
2810	CROWN-3/4 CAST METALLIC	215
2910	RECEMENT INLAY	16
2920	RECEMENT CROWN	15
2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50
2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	50
2932	PREFABRICATED RESIN CROWN	45
2940	SEDATIVE FILLINGS	16
2950	CROWN BUILDUP (SUBSTRUCTURE) WITH PINS	50
2951	PIN RETENTION-PER TOOTH IN ADDITION TO RESTORATION	9
2952	CAST POST & CORE IN ADDITION TO CROWN	65
2954	PREFAB POST & CORE IN ADDITION TO CROWN	55
2970	TEMPORARY CROWN (FRACTURED TOOTH)	45
2980	CROWN REPAIR	40
ENDODONTICS (ROOT CANALS)		
3110	PULP CAP-DIRECT EXCLUDING FINAL RESTORATION	4
3120	PULP CAP-INDIRECT EXCLUDING FINAL RESTORATION	3
3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	10
3310	ROOT CANAL THERAPY - ANTERIOR EXCLUDING FINAL RESTORATION	45
3320	ROOT CANAL THERAPY- BICUSPID EXCLUDING FINAL RESTORATION	60
3330	ROOT CANAL THERAPY- MOLAR EXCLUDING FINAL RESTORATION	85
3346	RETREATMENT-PREV ROOT CANAL THERAP-AN	65
3347	RETREATMENT-PREVROOT CANAL THERAP-BI	80
3348	RETREATMENT-PREVROOT CANAL THERAP-MO	90
3350	APEXIFICATION/RECALCIFICATION PER TREATMENT VISIT	20
3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	55
3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID FIRST ROOT	60
3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR FIRST ROOT	70
3426	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR EACH ADDIL ROOT	20
3430	RETROGRADE FILLING-PER ROOT	20
3450	ROOT AMPUTATION-PER ROOT	35
3920	HEMISECTION WITH ROOT REMOVAL-WITHOUT ROOT CANAL THERAPY	35
PERIODONTICS (GUM DISEASE)		
4210	GINGIVECTOMY/GINGIVOPLASTY-PER QUADRANT	45
4211	GINGIVECTOMY/GINGIVOPLASTY-PER TOOTH	15
4220	GINGIVAL CURETTAGE, SURGICAL-PER QUADRANT/-BY REPORT	20
4240	GINGIVAL FLAP PROCEDURE, INCL ROOT PLANING-PER QUADRANT	55
4249	CROWN LENGTHENING-HARD/SOFT TISSUE BY REPORT	65
4250	MUCO-GINGIVAL SURGERY-PER QUADRANT	60
4260	OSSEOUS SURGERY, INCLUDING FLAP ENTRY & CLOSURE	90
4261	OSSEOUS GRAFT	40
4262	OSSEOUS GRAFT, MULTIPLE	50
4268	GUID TISSUE REGENERATION INCLUDING SURGERY	60
4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	60
4271	FREE SOFT TISSUE GRAFT & DONOR SITE SURGERY	70
4320	PROVISIONAL SPLINTING - INTRACORONAL	20
4321	PROVISIONAL SPLINTING - EXTRACORONAL	20
4341	PERIODONTAL ROOT PLANING - PER QUADRANT	30
4355	FULL MOUTH DEBRIDEMENT BEFORE COMPREHENSIVE TRTMT (NOTE A)	15
4381	LOCAL DELIV CHEMOTHERAPY AGENTS (PREAUTHORIZATION REQ)	20
4910	PERIODONTAL MAINTENANCE AFTER ACTIVE THERAPY (NOTE B)	10
PROSTHETICS REMOVABLE (DENTURES)		
5110	COMPLETE DENTURE - UPPER	235
5120	COMPLETE DENTURE - LOWER	235
5130	IMMEDIATE DENTURE - UPPER	255
5140	IMMEDIATE DENTURE - LOWER	255



DENTAL

ADA CODE	PROCEDURE NAME	MEMBER PAYS
PROSTHETICS REMOVABLE (DENTURES) Continued		
5211	UPPER PARTIAL DENTURE-RESIN BASE INCLUDING CLASP	210
5212	LOWER PART DENTURE-RESIN BASE INCLUDING CLASP	210
5213	UPPER PARTIAL DENTURE-METAL BASE, RESIN SDL INCL CLASP	260
5214	LOWER PARTIAL DENTURE-METAL BASE, RESIN SDL INCL CLASP	260
5281	UNILATERAL PARTIAL DENTURE-METAL BASE, CAST CLASP	140
5410	ADJUST DENTURE-COMPLETE/PARTIAL, UPPER/LOWER	12
5510	REPAIR BROKEN COMPLETE DENTURE BASE	27
5520	REPLACE MISSING/BROKEN TOOTH-COMPLETE DENTURE-EACH TOOTH	22
5610	REPAIR ACRYLIC SADDLE OR BASE	25
5620	REPAIR CAST FRAMEWORK	30
5630	REPAIR OR REPLACE BROKEN CLASP	29
5640	REPLACE BROKEN TEETH-PER TOOTH	22
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	28
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	35
5710	REBASE DENTURE-COMPLETE/ PARTIAL, UPPER OR LOWER	90
5730	RELINE DENTURE-COMPLETE/PARTIAL, UPPER OR LOWER-CHAIRSIDE (NOTE C)	50
5750	RELINE DENTURE-COMPLETE/PARTIAL, UPPER OR LOWER-LAB (NOTE C)	70
5820	TEMPORARY PARTIAL STAYPLATE-UPPER OR LOWER	95
5850	TISSUE CONDITIONING UPPER - DENTURE	27
5851	TISSUE CONDITIONING LOWER - DENTURE	25
PROSTHETICS FIXED (BRIDGES)		
6210	PONTIC-CAST HIGH NOBLE METAL	215
6211	PONTIC-CAST PREDOMINANTLY BASE METAL	185
6212	PONTIC-CAST NOBLE METAL	190
6240	PONTIC-PORCELAIN FUSED TO HI NOBLE METAL	215
6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	190
6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	205
6520	INLAY-METALLIC-TWO SURFACES	150
6530	INLAY-METALLIC-3 OR MORE SURFACES	180
6540	ONLAY - METALLIC PER TOOTH + INLAY	120
6545	RTAIN-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	80
6750	CROWN-PORCELAIN FUSED TO HI NOBLE METAL	220
6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	195
6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	210
6780	CROWN-3/4 CAST HIGH NOBLE METAL	205
6790	CROWN-FULL CAST HIGH NOBLE METAL	215
6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	195
6792	CROWN-FULL CAST NOBLE METAL	205
6930	RECEMENT BRIDGE	22

ADA CODE	PROCEDURE NAME	MEMBER PAYS
ORAL SURGERY (EXTRACTIONS)		
7110	SINGLE TOOTH	10
7120	EACH ADDITIONAL TOOTH	10
7130	ROOT REMOVAL-EXPOSED ROOTS	10
7210	SURGICAL REMOVAL OF ERUPTED TOOTH	20
7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	25
7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	30
7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	40
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS-CUTTING PROCED	20
7260	OROANTRAL FISTULA CLOSURE	55
7270	TOOTH REPLANATATION	30
7280	SURGICAL EXPOSURE IMPACTED/UNERUPTED TOOTH-ORTHODONTIC	45
7281	SURGICAL EXPOSURE IMPACTED/UNERUPTED TOOTH-TO AID ERUPT	35
7285	BIOPSY OF ORAL TISSUE-HARD **	20
7286	BIOPSY OF ORAL TISSUE-SOFT **	25
7291	TRANSSEPTAL FIBEROTOMY	6
7310	ALVEOLOPLASTY IN CONJUNCTION W/EXTRACTIONS-PER QUADRANT	20
7320	ALVEOLOPLASTY NO EXTRACTIONS-PER QUADRANT	30
7470	REMOVAL EXOSTOSIS-MAXILLA OR MANDIBLE	45
7510	INCISION & DRAINING OF ABSCESS-INTRAORAL SOFT TISSUE	15
7910	SUTURE SIMPLE WOUNDS UP TO 5CM	8
7960	FRENULECTOMY (FRENECTOMY/FRENOTOMY) SEPARATE PROCEDURE	35
7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	25
7971	EXCISION OF PERICORONAL GINGIVA	15
ORTHODONTICS*		
8070	ORTHODONTIC FULLY BANDED (2 YR) CASE - TRANSITIONAL DENTITION	1,725
8080	ORTHODONTIC FULLY BANDED (2 YR) CASE - CHILD*	1,725
8090	ORTHODONTIC FULLY BANDED (2 YR) CASE - ADULT*	2,125
ADDITIONAL PROCEDURES		
9110	PALLIATIVE TREATMENT	5
9210	LOCAL ANESTHESIA	0
9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	30
9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MIN	9
9230	ANALGESIA	4
9240	INTRAVENOUS SEDATION PER 1/2 HOUR	25
9310	CONSULTATION (DIAGNOSTIC SVC BY NONTREATING PRACTITIONER)	10
9910	APPLICATION OF DESENSITIZING MEDICAMENT	3
9940	OCCLUSAL GUARDS BY REPORT	50
9951	OCCLUSAL ADJUSTMENT-LIMITED	10
9952	OCCLUSAL ADJUSTMENT-COMPLETE	45
9980	STERILIZATION SURCHARGE (PER VISIT)	5
9990	AFTER HOURS SURCHARGE	25
9999	BROKEN APPOINTMENT FEE (PER 1/2 HOUR)	15

FOOTNOTES:

Note: Procedures not shown are not covered by the dental plan.

NOTE A: Procedure 4355 (Full Mouth Debridement) - Limited to once per 36 months.

NOTE B: Procedure 4910 (Perio Maintenance After Active Therapy) - Limited to twice; must be within 12 months after osseous surgery.

NOTE C: Procedures 5730 and 5750 (Reline Dentures) - Limited to once per 36 months.

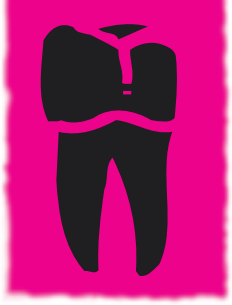
** - Lab fees for biopsies and excisions are to be paid by the patient.

* - Orthodontics for patients 19 and under at the time of banding are covered at the CHILD copayment.

Orthodontics for patients 20 and over at the time of banding are covered at the ADULT copayment. Treatment beyond 24 months is the responsibility of the patient. ORTHODONTIC treatment related to TMJ dysfunction is not covered. Patient pays an additional $250 for records. This is a separate additional fee.

Questions regarding plan benefits and features should be directed to DBP Customer Service at 1-877-566-3562.

Pedodontist care is excluded. Plan offers a 20% discount off the Pedodontist's charges.

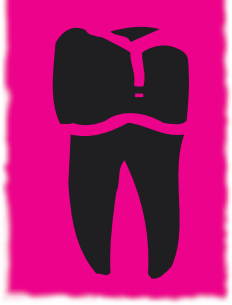


DENTAL

United Concordia DHMO
Schedule of Benefits

- This Schedule of Benefits contains additional services that are effective April 14, 2003.
- The member must select a participating provider site from which to receive in-network benefits.
- Members may transfer participating provider sites at any time. There is no limit to the number of changes allowed per year.
- Changes made after the 10th of the month are effective the 1st of the following month.
- Members must be referred to participating specialist sites by their participating provider site to receive in-network specialist benefits.
- The Company will allow referral of a member to a non-network specialist if all of the following conditions are met:
  (1) The member is diagnosed with a condition or disease that requires specialized care;
  (2) The Company does not have a specialist in its panel with the training and expertise to treat the condition or disease;
  (3) The member will be liable only for the applicable copayment, as indicated on the Schedule of Benefits.
- In the case of an accident or emergency involving acute pain or a condition requiring immediate treatment (but not hospitalization), occurring more than fifty (50) miles from the Member's home, the Dental Plan covers the cost of all necessary diagnostic and therapeutic dental procedures administered by a general dentist up to $50 for each accident or emergency, subject to the member's copayment.

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS
Clinical Oral Examinations		
D0120	Periodic Oral Evaluation	$0.00
D0140	Limited Oral Evaluation - Problem Focused	0.00
D0150	Comprehensive Oral Evaluation	0.00
D0170	Re-evaluation - Limited, Problem Focused (eff. 01/2002)	0.00
D0180	Comprehensive Periodontal Evaluation (eff. 04/2003)	0.00
Radiographs		
D0210	Intraoral - Complete Series (incl. Bitewings)	$0.00
D0220	Intraoral - Single Film	0.00
D0230	Intraoral - Each Add'l Film	0.00
D0240	Intraoral - Occlusal Film	0.00
D0270	Bitewings - Single Film	0.00
D0272	Bitewings - 2 Films	0.00
D0274	Bitewings - 4 Films	0.00
D0277	Bitewing - 7 to 8 films (eff. 01/2002)	0.00
D0330	Panoramic X-Ray	0.00
D0340	Cephalometric Film	0.00
Tests & Lab Examinations		
D0460	Pulp Vitality Tests	$0.00
D0470	Diagnostic Casts	0.00
Dental Prophylaxis		
D1110	Prophylaxis (Cleaning) - Adult (1 per 6 months)	$0.00
D1120	Prophylaxis (Cleaning) - Child (1 per 6 months)	0.00
Topical Fluoride Treatment		
D1203	Topical App. of Fluoride Tx - Child (exclude prophy)	$0.00
D1204	Topical App. of Fluoride Tx - Adult (exclude prophy)	0.00
Other Preventive Services		
D1330	Oral Hygiene Instruction	$0.00
D1351	Sealant - Per Tooth (Child)	0.00
Space Maintenance (Passive Appliances)		
D1510	Space Maintainer -Fixed Unilateral	$0.00
D1515	Space Maintainer-Fixed Bilateral	0.00
D1520	Space Maintainer-Removable Unilateral	0.00
Amalgam Restorations	(Incl. Local Anesthesia & Polishing)	
D2140	Amalgam - one surface, primary or permanent	$0.00
D2150	Amalgam - two surfaces - primary or permanent	0.00
D2160	Amalgam - three surfaces - primary or permanent	0.00
D2161	Amalgam - four or more surfaces, primary or permanent	0.00
Resin Restorations (Incl. Local Anesthesia)		
D2330	Resin - one surface, anterior	$0.00
D2331	Resin - two surfaces, anterior	0.00
D2332	Resin - three surfaces, anterior	0.00
D2335	Resin - four or more surfaces or involving incisal angle anterior	70.00
D2391	Resin - one surface, posterior	36.00
D2392	Resin - two surfaces, posterior	50.00
D2393	Resin - three surfaces, posterior	60.00
D2394	Resin - four or more surfaces, posterior	70.00
Inlay Restorations		
D2510	Inlay - metallic one surface	$60.00
D2520	Inlay - metallic two surfaces	100.00
D2530	Inlay - metallic three or more surfaces	120.00
D2542	Onlay - metallic - two surfaces (eff. 01/2002)	20.00
D2543	Onlays - metallic - three surfaces	30.00
D2544	Onlays - metallic - four or more surfaces	50.00
Crowns - Single Restoration		
D2710	Crown - Resin (laboratory)	$64.00
D2740	Crown - porcelain/ceramic substrate	225.00
D2750	Crown - porcelain fused to high noble metal	230.00
D2751	Crown - porcelain fused to predom. base metal	215.00
D2752	Crown - porcelain fused to noble metal	225.00
D2780	Crown - 3/4 cast high noble metal (eff. 01/2002)	190.00
D2781	Crown - 3/4 cast predominately base metal (eff. 01/2002)	190.00
D2782	Crown - 3/4 cast noble metal (eff. 01/2002)	190.00
D2783	Crown - 3/4 porcelain/ceramic (eff. 01/2002)	190.00
Crowns - Single Restoration (Continued)		
D2790	Crown - full cast high noble metal	$190.00
D2791	Crown - full cast predominantly base metal	215.00
D2792	Crown - full cast noble metal	220.00
Other Restorative Services		
D2910	Recement inlay	$15.00
D2920	Recement crown	15.00
D2930	Prefabricated stainless steel crown (Prim. Tooth)	48.00
D2931	Prefabricated stainless steel crown (Perm. Tooth)	56.00
D2940	Sedative filling	0.00
D2950	Core buildup, including pins	90.00
D2951	Pin retention - per tooth in addition to restoration	10.00
D2952	Cast post & core in addition to crown	90.00
D2953	Each additional cast post - same tooth (eff. 01/2002)	45.00
D2954	Prefabricated post & core in addition to crown	90.00
D2957	Each add'l prefabricated post-same tooth (eff. 01/2002)	45.00
Pulp Capping		
D3110	Pulp Cap - Direct (excluding final restoration)	$0.00
D3120	Pulp Cap - Indirect (excluding final restoration)	0.00
Pulpotomy		
D3220	Therapeutic Pulpotomy	$25.00
D3221	Gross pulpal debridement (eff. 01/2002)	15.00
D3230	Pulpal Therapy (resorbable filling) - anterior primary (excluding final restoration)	40.00
D3240	Pulpal Therapy (resorbable filling) - posterior primary (excluding final restoration)	55.00
Root Canal Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)		
D3310	Anterior (excluding final restoration)	$90.00
D3320	Bicuspid (excluding final restoration)	120.00
D3330	Molar (excluding final restoration)	165.00
Retreatment (Including Root Canal Therapy)		
D3346	Retreatment of previous root canal therapy - anterior	$165.00
D3347	Retreatment of previous root canal therapy - bicuspid	195.00
D3348	Retreatment of previous root canal therapy - molar	240.00
Periapical Services		
D3410	Apicoectomy/Periradicular surgery - anterior	$107.00
D3421	Apicoectomy/Periradicular surgery - bicuspid 1st root	107.00
D3425	Apicoectomy/Periradicular surgery - molar 1st root	107.00
D3426	Apicoectomy/Periradicular surgery - (each add'l root)	41.00
D3450	Root amputation - per root	50.00
Other Endodontic Procedures		
D3920	Hemisection - incl. any root removal but not root canal therapy	$41.00
Surgical Services (Including Usual Postoperative Services)		
D4210	Gingivectomy or Gingivoplasty - four or more, per quad	$125.00
D4211	Gingivectomy or Gingivoplasty - one to three, per quad	50.00
D4240	Gingival flap, including root planing - four or more, per quad	135.00
D4241	Gingival flap, including root planing - one to three, per quad (eff. 04/2003)	54.00
D4245	Apically repositioned flap (eff. 01/2002)	110.00
D4249	Clinical crown lengthening - hard tissue	105.00
D4260	Osseous Surgery - four or more, per quadrant (including flap entry & closure)	210.00
D4261	Osseous Surgery - one to three, per quadrant (including flap entry & closure) (eff. 04/2003)	110.00
D4263	Bone Replacement Graft	115.00
D4271	Free soft tissue graft procedure - per tooth (including donor site)	100.00
D4274	Distal or proximal wedge	45.00
D4275	Soft Tissue Allograft (eff. 04/2003)	100.00
D4276	Combined connective tissue and double pedicle graft (eff. 04/2003)	100.00
Adjunctive Periodontal Services		
D4320	Provisional splinting - intracoronal per tooth	$40.00
D4321	Provisional splinting - extracoronal per tooth	40.00
D4341	Periodontal scaling & root planing - four or more, per quad	50.00



DENTAL

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS
Adjunctive Periodontal Services (Continued)		
D4342	Periodontal scaling & root planing - one to three, per quad (eff. 04/2003)	$13.00
D4355	Full mouth debridement (one in 24 months)	50.00
D4381	Localized delivery of chemotheraputic agents, per tooth (eff. 04/2003)	100.00
Other Periodontal Services		
D4910	Periodontal maintenance	$25.00
Complete Dentures (Including Routine Post-Delivery Care)		
D5110	Complete denture -maxillary	$220.00
D5120	Complete denture -mandibular	220.00
D5130	Immediate denture -maxillary	240.00
D5140	Immediate denture -mandibular	240.00
Partial Denture (Including Routine Post-Delivery Care)		
D5211	Maxillary Partial Dentures Resin Base- Upper (incl. any conventional clasps, rests & teeth)	$145.00
D5212	Mandibular Partial Dentures Resin Base- Lower (incl. any conventional clasps, rests & teeth)	145.00
D5213	Maxillary Partial Dentures Cast Base- Upper (incl. any conventional clasps, rests & teeth)	225.00
D5214	Mandibular Partial Dentures Cast Base- Lower (incl. any conventional clasps, rests & teeth)	225.00
D5281	Removable Unilateral Partial Denture One Piece Cast Metal (incl. clasps & pontics)	65.00
Adjustments to Removable Prosthesis		
D5410	Adjust complete denture - maxillary	$7.00
D5411	Adjust complete denture - mandibular	7.00
D5421	Adjust partial denture - maxillary	7.00
D5422	Adjust partial denture - mandibular	7.00
Repairs to Complete and Partial Dentures		
D5510	Repair broken complete denture base	$21.00
D5520	Replace missing/broken teeth (complete denture) - each tooth	28.00
D5610	Repair resin denture base	23.00
D5620	Repair cast framework	33.00
D5630	Repair/replace broken clasp	23.00
D5640	Replace broken teeth - per tooth	18.00
D5650	Add tooth to existing partial denture	23.00
D5660	Add clasp to existing partial denture	33.00
D5670	Replace all teeth & acrylic on cast metal frame (maxillary) (eff. 04/2003)	147.00
D5671	Replace all teeth & acrylic on cast metal frame (mandibular) (eff. 04/2003)	147.00
Denture Rebase Procedures		
D5710	Rebase complete maxillary denture	$55.00
D5711	Rebase complete mandibular denture	55.00
D5720	Rebase maxillary partial denture	48.00
D5721	Rebase mandibular partial denture	48.00
Denture Reline Procedures		
D5730	Reline complete maxillary (chairside)	$40.00
D5731	Reline complete mandibular (chairside)	40.00
D5740	Reline partial maxillary (chairside)	40.00
D5741	Reline partial mandibular (chairside)	40.00
D5750	Reline complete maxillary (laboratory)	55.00
D5751	Reline complete mandibular (laboratory)	55.00
D5760	Reline maxillary partial denture (laboratory)	55.00
D5761	Reline mandibular partial denture (laboratory)	55.00
Other Removable Prosthetic Services		
D5810	Interim complete temporary denture - maxillary	$125.00
D5811	Interim complete temporary denture - mandibular	125.00
D5820	Interim partial temporary denture - maxillary	105.00
D5821	Interim partial temporary denture - mandibular	105.00
D5850	Tissue conditioning - maxillary	25.00
D5851	Tissue conditioning - mandibular	25.00
Bridge Pontics		
D6210	Pontic-cast high noble metal	$230.00
D6211	Pontic-cast predominantly base metal	215.00
D6212	Pontic-cast noble metal	220.00
D6240	Pontic-porcelain fused to high noble metal	230.00
D6241	Pontic-porcelain fused to predominantly base metal	215.00
D6242	Pontic-porcelain fused to noble metal	220.00
D6245	Pontic - porcelain, ceramic (eff. 01/2002)	215.00
Bridge Retainers - Inlays/Onlays		
D6610	Onlay-cast high noble metal, two surfaces (eff. 04/2003)	$150.00
D6612	Onlay-cast predominantly base metal, two surfaces (eff. 04/2003)	100.00
D6614	Onlay-cast noble metal, two surfaces (eff. 04/2003)	125.00

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS
Bridge Retainers - Crowns		
D6740	Crown - porcelain, ceramic (eff. 01/2002)	$215.00
D6750	Crown-porcelain fused to high noble metal	230.00
D6751	Crown-porcelain fused to predominantly base metal	215.00
D6752	Crown-porcelain fused to noble metal	220.00
D6790	Crown-full cast high noble metal	230.00
D6791	Crown-full cast predominantly base metal	215.00
D6792	Crown-full cast noble metal	220.00
Other Fixed Prosthetic Services		
D6930	Recement bridge	$17.00
Extractions (Including Local Anesthesia and Routine Postoperative Care)		
D7111	Coronal remnants - deciduous tooth (eff. 04/2003)	$7.00
D7140	Extraction, erupted tooth or exposed root	17.00
Surgical Extractions - (Including Local Anesthesia & Routine Postoperative Care)		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$27.00
D7220	Removal of impacted tooth - soft tissue	45.00
D7230	Removal of impacted tooth - partially bony	55.00
D7240	Removal of impacted tooth - completely bony	65.00
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	80.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	35.00
Other Surgical Procedures		
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including ortho. attachments)	$65.00
D7285	Biopsy of oral tissue-hard (bone, tooth)	35.00
D7286	Biopsy of oral tissue-soft (all others)	28.00
D7310	Alveoloplasty - in conjunction w/extraction per quad	$23.00
D7320	Alveoloplasty-not in conjunction w/extraction per quad	30.00
D7450	Surgical excision - cyst	60.00
D7471	Remove Exostosis	60.00
D7472	Removal of torus palatinus (eff. 04/2003)	60.00
D7473	Removal of torus mandibularis (eff. 04/2003)	60.00
D7485	Surgical reduction of osseous tuberosity (eff. 04/2003)	60.00
D7510	Incision & drainage of abscess - intraoral	35.00
D7960	Frenulectomy (frenectomy or frenotomy)-sep.proc.	53.00
D7972	Surgical reduction of fibrous tuberosity (eff. 04/2003)	60.00
Orthodontics		
D8010	Limited Ortho. Treatment - primary dentition	$380.00
D8020	Limited Ortho. Treatment - transitional dentition	405.00
D8030	Limited Ortho. Treatment - adolescent dentition	430.00
D8040	Limited Ortho. Treatment - adult dentition	455.00
D8050	Interceptive - primary dentition	650.00
D8060	Interceptive - transitional dentition	750.00
D8070	Comprehensive - transitional	1,650.00
D8080	Comprehensive - adolescent	1,700.00
D8090	Comprehensive - adult	1,750.00
Minor Treatment to Control Harmful Habits	(Includes appliance and 6 months of treatment prior to comprehensive ortho treatment).	
D8210	Removable appliance therapy (6 months)	$390.00
D8220	Fixed appliance therapy (6 months)	370.00
Other Orthodontic Services		
D8660	Pre-orthodontic treatment visit	$75.00
D8670	Periodic orthodontic treatment visit	65.00
D8680	Orthodontic retention	150.00
Unclassified Treatment		
D9110	Palliative (emergency) treatment of dental pain, minor procedures	$15.00
Professional Consultation		
D9310	Consultation - diagnostic service provided by dentist or physician other than practitioner providing treatment	$20.00
Professional Visits		
*	Broken appointment chg, - per 15 min. (without 24-hour notice)	$10.00
D9440	Office Visit (after hours)	30.00
Miscellaneous Services		
D9630	Medicinal Irrigation	$20.00
D9951	Occlusal Adjustment - Limited (fewer than 12 teeth)	20.00
D9952	Occlusal Adjustment - Complete	45.00

Child (Age 12 or under)
Adult (Ages 13 +)

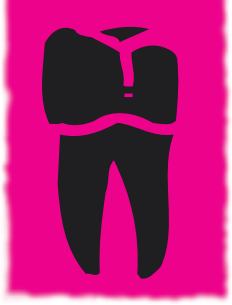
* Please report under code D9999.

• Procedure codes and member copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.

NON-COVERED SERVICES

- Please note that only the services listed on this Schedule of Benefits are covered. If a service is not listed, it is not covered and the member is responsible for the full fee charged by the dentist.
- Please refer to your Benefit Guide and to the Exclusions and Limitations in addition to this Schedule of Benefits for a complete description of your plan.
- Services for injuries and conditions which are covered by Worker's Compensation for employees liability laws.
- Services that cannot be performed because of the general health of the patient.
- Procedures performed which are cosmetic, elective, experimental or investigative in nature. Experimental or Investigative is defined as the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company relying on the advice of the the general dental community which includes, but is not limited to dental consultants, dental journals and/or government regulations, determines are not acceptable dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval for which approval has not been granted at the time the services were rendered. Please refer to the Exclusions and Limitations Section of your Benefit Guide.

Questions regarding plan benefits and features should be directed to UCCI Customer Service at 1-888-638-3384 (1-888-MD TEETH) TTY Hearing Impaired 1-800-859-5846.

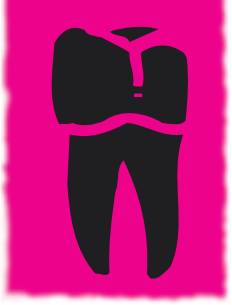


DENTAL

United Concordia DPOS
Schedule of Benefits

- This Schedule of Benefits contains additional services that are effective April 14, 2003.
- The member must select a participating provider site from which to receive in-network benefits.
- Members may transfer participating provider sites at any time. There is no limit to the number of changes allowed per year.
- Changes made after the 10th of the month are effective the 1st of the following month.
- Members must be referred to participating specialist sites by their participating provider site to receive in-network specialist benefits.
- In the case of an accident or emergency involving acute pain or a condition requiring immediate treatment (but not hospitalization), occurring more than fifty (50) miles from the Member's home, the Dental Plan covers the cost of all necessary diagnostic and therapeutic dental procedures administered by a general dentist up to $50 for each accident or emergency, subject to the member's copayment.
- Out-of-Network benefit maximum is $1,000 per member per calendar year.

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	OUT-OF NETWORK PLAN PAYS UP TO $
Clinical Oral Examinations			
D0120	Periodic Oral Evaluation	$0.00	$11.00
D0140	Limited Oral Evaluation - Problem Focused	0.00	12.00
D0150	Comprehensive Oral Evaluation	0.00	12.00
D0170	Re-evaluation - Limited, Problem Focused (eff. 01/2002)	0.00	12.00
D0180	Comprehensive Periodontal Evaluation (eff. 04/2003)	0.00	12.00
Radiographs			
D0210	Intraoral - Complete Series (incl. Bitewings)	$0.00	$33.00
D0220	Intraoral - Single Film	0.00	6.00
D0230	Intraoral - Each Add'l Film	0.00	4.00
D0240	Intraoral - Occlusal Film	0.00	9.00
D0270	Bitewings - Single Film	0.00	6.00
D0272	Bitewings - 2 Films	0.00	11.00
D0274	Bitewings - 4 Films	0.00	15.00
D0277	Bitewing - 7 to 8 films (eff. 01/2002)	0.00	15.00
D0330	Panoramic X-Ray	0.00	30.00
D0340	Cephalometric Film	0.00	30.00
Tests & Lab Examinations			
D0460	Pulp Vitality Tests	$0.00	$14.00
D0470	Diagnostic Casts	0.00	15.00
Dental Prophylaxis			
D1110	Prophylaxis (Cleaning) - Adult (1 per 6 months)	$0.00	$18.00
D1120	Prophylaxis (Cleaning) - Child (1 per 6 months)	0.00	14.00
Topical Fluoride Treatment			
D1203	Topical App. of Fluoride Tx - Child (exclude prophy)	$0.00	$10.00
D1204	Topical App. of Fluoride Tx - Adult (exclude prophy)	0.00	10.00
Other Preventive Services			
D1330	Oral Hygiene Instruction	$0.00	$0.00
D1351	Sealant - Per Tooth (Child)	0.00	6.00
Space Maintenance (Passive Appliances)			
D1510	Space Maintainer-Fixed Unilateral	$0.00	$55.00
D1515	Space Maintainer-Fixed Bilateral	0.00	114.00
D1520	Space Maintainer-Removable Unilateral	0.00	35.00
Amalgam Restorations (Incl. Local Anesthesia & Polishing)			
D2140	Amalgam - one surface, primary or permanent	$0.00	$20.00
D2150	Amalgam - two surfaces - primary or permanent	0.00	27.00
D2160	Amalgam - three surfaces - primary or permanent	0.00	35.00
D2161	Amalgam - four or more surfaces, primary or permanent	0.00	41.00
Resin Restorations (Incl. Local Anesthesia)			
D2330	Resin - one surface, anterior	$0.00	$24.00
D2331	Resin - two surfaces, anterior	0.00	36.00
D2332	Resin - three surfaces, anterior	0.00	45.00
D2335	Resin - four or more surfaces or involving incisal angle anterior	70.00	54.00
D2391	Resin - one surface, posterior	36.00	$28.00
D2392	Resin - two surfaces, posterior	50.00	40.00
D2393	Resin - three surfaces, posterior	60.00	48.00
D2394	Resin - four or more surfaces, posterior	70.00	56.00
Inlay Restorations			
D2510	Inlay - metallic one surface	$60.00	$66.00
D2520	Inlay - metallic two surfaces	100.00	110.00
D2530	Inlay - metallic three or more surfaces	120.00	132.00
D2542	Onlay - metallic - two surfaces (eff. 01/2002)	20.00	40.00
D2543	Onlays - metallic - three surfaces	30.00	50.00
D2544	Onlays - metallic - four or more surfaces	50.00	66.00
Crowns - Single Restoration			
D2710	Crown - Resin (laboratory)	$64.00	$64.00
D2740	Crown - porcelain/ceramic substrate	225.00	210.00
D2750	Crown - porcelain fused to high noble metal	230.00	220.00
D2751	Crown - porcelain fused to predom. base metal	215.00	200.00
D2752	Crown - porcelain fused to noble metal	225.00	210.00
D2780	Crown - 3/4 cast high noble metal (eff. 01/2002)	190.00	190.00
D2781	Crown - 3/4 cast predominately base metal (eff. 01/2002)	190.00	190.00
D2782	Crown - 3/4 cast noble metal (eff. 01/2002)	190.00	190.00
D2783	Crown - 3/4 porcelain/ceramic (eff. 01/2002)	190.00	190.00
D2790	Crown - full cast high noble metal	230.00	220.00
D2791	Crown - full cast predominantly base metal	215.00	200.00
D2792	Crown - full cast noble metal	220.00	210.00
Other Restorative Services			
D2910	Recement inlay	$15.00	$12.00
D2920	Recement crown	15.00	17.00
D2930	Prefabricated stainless steel crown (Prim. Tooth)	48.00	48.00
D2931	Prefabricated stainless steel crown (Perm. Tooth)	56.00	56.00
D2940	Sedative filling	0.00	20.00
D2950	Core buildup, including pins	90.00	40.00
D2951	Pin retention - per tooth in addition to restoration	10.00	7.00
D2952	Cast post & core in addition to crown	90.00	60.00
D2953	Each additional cast post - same tooth (eff. 01/2002)	45.00	44.00
D2954	Prefabricated post & core in addition to crown	90.00	44.00
D2957	Each add'l prefabricated post-same tooth (eff. 01/2002)	45.00	44.00
Pulp Capping			
D3110	Pulp Cap - Direct (excluding final restoration)	$0.00	$12.00
D3120	Pulp Cap - Indirect (excluding final restoration)	0.00	12.00
Pulpotomy			
D3220	Therapeutic Pulpotomy	$25.00	$38.00
D3221	Gross pulpal debridement (eff. 01/2002)	15.00	20.00
D3230	Pulpal Therapy (resorbable filling) - anterior primary (excluding final restoration)	40.00	50.00
D3240	Pulpal Therapy (resorbable filling) - posterior primary (excluding final restoration)	55.00	50.00
Root Canal Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)			
D3310	Anterior (excluding final restoration)	$90.00	$143.00
D3320	Bicuspid (excluding final restoration)	120.00	167.00
D3330	Molar (excluding final restoration)	165.00	231.00
Retreatment (Including Root Canal Therapy)			
D3346	Retreatment of previous root canal therapy - anterior	$165.00	$220.00
D3347	Retreatment of previous root canal therapy - bicuspid	195.00	260.00
D3348	Retreatment of previous root canal therapy - molar	240.00	320.00
Periapical Services			
D3410	Apicoectomy/Periradicular surgery - anterior	$107.00	$167.00
D3421	Apicoectomy/Periradicular surgery - bicuspid 1st root	107.00	168.00
D3425	Apicoectomy/Periradicular surgery - molar 1st root	107.00	168.00
D3426	Apicoectomy/Periradicular surgery - (each add'l root)	41.00	65.00
D3450	Root amputation - per root	50.00	77.00
Other Endodontic Procedures			
D3920	Hemisection - incl. any root removal but not root canal therapy	$41.00	$64.00
Surgical Services (Including Usual Postoperative Services)			
D4210	Gingivectomy or Gingivoplasty - four or more, per quad	$125.00	$192.00
D4211	Gingivectomy or Gingivoplasty - one to three, per quad	50.00	30.00
D4240	Gingival flap, incl. root planing - four or more, per quad	135.00	205.00
D4241	Gingival flap, including root planing - one to three, per quad (eff. 04/2003)	54.00	82.00
D4245	Apically repositioned flap (eff. 01/2002)	110.00	168.00
D4249	Clinical crown lengthening - hard tissue	105.00	140.00
D4260	Osseous Surgery - four or more, per quadrant (including flap entry & closure)	210.00	225.00
D4261	Osseous Surgery - one to three, per quadrant (including flap entry & closure) (eff. 04/2003)	110.00	90.00
D4263	Bone Replacement Graft	115.00	75.00
D4271	Free soft tissue graft procedure - per tooth (including donor site)	100.00	154.00
D4274	Distal or proximal wedge	45.00	75.00
D4275	Soft Tissue Allograft (eff. 04/2003)	100.00	154.00
D4276	Combined connective tissue and double pedicle graft (eff. 04/2003)	100.00	154.00
Adjunctive Periodontal Services			
D4320	Provisional splinting - intracoronal per tooth	$40.00	$50.00
D4321	Provisional splinting - extracoronal per tooth	40.00	50.00
D4341	Periodontal scaling & root planing - four or more, per quad	50.00	38.00
D4342	Periodontal scaling & root planing - one to three, per quad (eff. 04/2003)	13.00	10.00
D4355	Full mouth debridement (one in 24 months)	50.00	36.00
D4381	Localized delivery of chemotheraputic agents, per tooth (eff. 04/2003)	100.00	50.00
Other Periodontal Services			
D4910	Periodontal maintenance	$25.00	$31.00



DENTAL

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	OUT-OF NETWORK PLAN PAYS UP TO $
Complete Dentures (Including Routine Post-Delivery Care)			
D5110	Complete denture -maxillary	$220.00	$220.00
D5120	Complete denture -mandibular	220.00	220.00
D5130	Immediate denture -maxillary	240.00	220.00
D5140	Immediate denture -mandibular	240.00	220.00
Partial Denture (Including Routine Post-Delivery Care)			
D5211	Maxillary Partial Dentures Resin Base- Upper (incl. any conventional clasps, rests & teeth)	$145.00	$176.00
D5212	Mandibular Partial Dentures Resin Base- Lower (incl. any conventional clasps, rests & teeth)	145.00	176.00
D5213	Maxillary Partial Dentures Cast Base- Upper (incl. any conventional clasps, rests & teeth)	225.00	255.00
D5214	Mandibular Partial Dentures Cast Base- Lower (incl. any conventional clasps, rests & teeth)	225.00	255.00
D5281	Removable Unilateral Partial Denture One Piece Cast Metal (incl. clasps & pontics)	65.00	66.00
Adjustments to Removable Prosthesis			
D5410	Adjust complete denture - maxillary	$7.00	$23.00
D5411	Adjust complete denture - mandibular	7.00	23.00
D5421	Adjust partial denture - maxillary	7.00	23.00
D5422	Adjust partial denture - mandibular	7.00	23.00
Repairs to Complete and Partial Dentures			
D5510	Repair broken complete denture base	$21.00	$28.00
D5520	Replace missing/broken teeth (complete denture) - each tooth	28.00	38.00
D5610	Repair resin denture base	23.00	35.00
D5620	Repair cast framework	33.00	81.00
D5630	Repair/replace broken clasp	23.00	44.00
D5640	Replace broken teeth - per tooth	18.00	23.00
D5650	Add tooth to existing partial denture	23.00	30.00
D5660	Add clasp to existing partial denture	33.00	46.00
D5670	Replace all teeth & acrylic on cast metal frame (maxillary) (eff. 04/2003)	147.00	150.00
D5671	Replace all teeth & acrylic on cast metal frame (mandibular) (eff. 04/2003)	147.00	150.00
Denture Rebase Procedures			
D5710	Rebase complete maxillary denture	$55.00	$79.00
D5711	Rebase complete mandibular denture	55.00	79.00
D5720	Rebase maxillary partial denture	48.00	67.00
D5721	Rebase mandibular partial denture	48.00	67.00
Denture Reline Procedures			
D5730	Reline complete maxillary (chairside)	$40.00	$59.00
D5731	Reline complete mandibular (chairside)	40.00	59.00
D5740	Reline partial maxillary (chairside)	40.00	59.00
D5741	Reline partial mandibular (chairside)	40.00	59.00
D5750	Reline complete maxillary (laboratory)	55.00	77.00
D5751	Reline complete mandibular (laboratory)	55.00	77.00
D5760	Reline maxillary partial denture (laboratory)	55.00	77.00
D5761	Reline mandibular partial denture (laboratory)	55.00	77.00
Other Removable Prosthetic Services			
D5810	Interim complete temporary denture - maxillary	$125.00	$125.00
D5811	Interim complete temporary denture - mandibular	125.00	125.00
D5820	Interim partial temporary denture - maxillary	105.00	105.00
D5821	Interim partial temporary denture - mandibular	105.00	105.00
D5850	Tissue conditioning - maxillary	25.00	49.00
D5851	Tissue conditioning - mandibular	25.00	49.00
Bridge Pontics			
D6210	Pontic-cast high noble metal	$230.00	$220.00
D6211	Pontic-cast predominantly base metal	215.00	200.00
D6212	Pontic-cast noble metal	220.00	210.00
D6240	Pontic-porcelain fused to high noble metal	230.00	220.00
D6241	Pontic-porcelain fused to predominantly base metal	215.00	200.00
D6242	Pontic-porcelain fused to noble metal	220.00	210.00
D6245	Pontic - porcelain, ceramic (eff. 01/2002)	215.00	200.00
Bridge Retainers - Inlays/Onlays			
D6610	Onlay-cast high noble metal, two surfaces (eff. 04/2003)	$150.00	$90.00
D6612	Onlay-cast predominantly base metal, two surfaces (eff. 04/2003)	100.00	50.00
D6614	Onlay-cast noble metal, two surfaces (eff. 04/2003)	125.00	70.00
Bridge Retainers - Crowns			
D6740	Crown - porcelain, ceramic (eff. 01/2002)	$215.00	$200.00
D6750	Crown-porcelain fused to high noble metal	230.00	220.00
D6751	Crown-porcelain fused to predominantly base metal	215.00	200.00
Bridge Retainers - Crowns (Continued)			
D6752	Crown-porcelain fused to noble metal	$220.00	$210.00
D6790	Crown-full cast high noble metal	230.00	220.00
D6791	Crown-full cast predominantly base metal	215.00	200.00
D6792	Crown-full cast noble metal	220.00	210.00
Other Fixed Prosthetic Services			
D6930	Recement bridge	$17.00	$26.00
Extractions (Including Local Anesthesia and Routine Postoperative Care)			
D7111	Coronal remnants - deciduous tooth (eff. 04/2003)	$7.00	$11.00
D7140	Extraction, erupted tooth or exposed root	17.00	26.00
Surgical Extractions - (Including Local Anesthesia & Routine Postoperative Care)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$27.00	$32.00
D7220	Removal of impacted tooth - soft tissue	45.00	44.00
D7230	Removal of impacted tooth - partially bony	55.00	77.00
D7240	Removal of impacted tooth - completely bony	65.00	92.00
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	80.00	115.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	35.00	53.00
Other Surgical Procedures			
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including ortho. attachments)	$65.00	$100.00
D7285	Biopsy of oral tissue-hard (bone, tooth)	35.00	65.00
D7286	Biopsy of oral tissue-soft (all others)	28.00	44.00
D7310	Alveoloplasty - in conjunction w/extraction per quad	$23.00	$36.00
D7320	Alveoloplasty - not in conjunction w/extraction per quad	30.00	46.00
D7450	Surgical excision - cyst	60.00	110.00
D7471	Remove Exostosis	60.00	140.00
D7472	Removal of torus palatinus (eff. 04/2003)	60.00	140.00
D7473	Removal of torus mandibularis (eff. 04/2003)	60.00	140.00
D7485	Surgical reduction of osseous tuberosity (eff. 04/2003)	60.00	140.00
D7510	Incision & drainage of abscess - intraoral	35.00	17.00
D7960	Frenulectomy (frenectomy or frenotomy)-sep.proc.	53.00	82.00
D7972	Surgical reduction of fibrous tuberosity (eff. 04/2003)	60.00	140.00
Orthodontics			
D8010	Limited Ortho. Treatment - primary dentition	$380.00	$0.00
D8020	Limited Ortho. Treatment - transitional dentition	405.00	0.00
D8030	Limited Ortho. Treatment - adolescent dentition	430.00	0.00
D8040	Limited Ortho. Treatment - adult dentition	455.00	0.00
D8050	Interceptive - primary dentition	650.00	0.00
D8060	Interceptive - transitional dentition	750.00	0.00
D8070	Comprehensive - transitional	1,650.00	0.00
D8080	Comprehensive - adolescent	1,700.00	0.00
D8090	Comprehensive - adult	1,750.00	0.00
Minor Treatment to Control Harmful Habits			
	(Includes appliance and 6 months of treatment prior to comprehensive ortho treatment).		
D8210	Removable appliance therapy (6 months)	$390.00	$0.00
D8220	Fixed appliance therapy (6 months)	370.00	0.00
Other Orthodontic Services			
D8660	Pre-orthodontic treatment visit	$75.00	$0.00
D8670	Periodic orthodontic treatment visit	65.00	0.00
D8680	Orthodontic retention	150.00	0.00
Unclassified Treatment			
D9110	Palliative (emergency) treatment of dental pain, minor procedures	$15.00	$20.00
Professional Consultation			
D9310	Consultation - diagnostic service provided by dentist or physician other than practitioner providing treatment	$20.00	$30.00
Professional Visits			
	* Broken appointment chg. - per 15 min. (without 24-hour notice)	$10.00	$0.00
D9440	Office Visit (after hours)	30.00	30.00
Miscellaneous Services			
D9630	Medicinal Irrigation	$20.00	$10.00
D9951	Occlusal Adjustment - Limited (fewer than 12 teeth)	20.00	15.00
D9952	Occlusal Adjustment - Complete	45.00	145.00
	Child (Age 12 or under)		
	Adult (Ages 13 +)		

* Please report under code D9999.

• Procedure codes and member copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.

NON-COVERED SERVICES

- Please note that only the services listed on this Schedule of Benefits are covered. If a service is not listed, it is not covered and the member is responsible for the full fee charged by the dentist.
- Please refer to your Benefit Guide and to the Exclusions and Limitations in addition to this Schedule of Benefits for a complete description of your plan.
- Services for injuries and conditions which are covered by Worker's Compensation for employees liability laws.
- Services that cannot be performed because of the general health of the patient.

Procedures performed which are cosmetic, elective, experimental or investigative in nature. Experimental or Investigative is defined as the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company relying on the advice of the the general dental community which includes, but is not limited to dental consultants, dental journals and/or government regulations, determines are not acceptable dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval for which approval has not been granted at the time the services were rendered. Please refer to the Exclusions and Limitations Section of your Benefit Guide.

Questions regarding plan benefits and features should be directed to UCCI Customer Service at 1-888-638-3384 (1-888-MD TEETH) TTY Hearing Impaired 1-800-859-5846.

MENTAL HEALTH/ SUBSTANCE ABUSE ■

MENTAL HEALTH/SUBSTANCE ABUSE PLAN

General Description of Coverage

Mental Health and Substance Abuse plan coverage is available to all individuals and their dependents who carry medical plan coverage with the State of Maryland. You automatically have mental health and substance abuse benefits when you enroll in any of the State sponsored medical plans. However, your mental health and substance abuse benefits vary depending on the medical plan in which you are enrolled. **The State's Mental Health and Substance Abuse plan for individuals enrolled in PPO and POS medical plans is administered by APS Healthcare, Inc. (APS).** Individuals enrolled in HMO medical plans receive all mental health and substance abuse coverage through their HMO. You cannot obtain mental health and substance abuse benefits through the State if you do not enroll in a State medical plan.

No additional premium is required. The cost of your mental health and substance abuse coverage is included in your medical plan premium.

How to Receive Mental Health and Substance Abuse Benefits

HMO Medical Plan: If you are enrolled in an HMO medical plan, all mental health and substance abuse services must be authorized by your HMO. Please contact your medical plan for more details. Their phone numbers are located on the back cover of this book.

Standard Mental Health and Substance Abuse Benefits Chart for Individuals Enrolled in HMO Medical Plans (Benefits administered by your HMO medical plan)

Benefit -- If you are enrolled in an HMO, all your mental health and substance abuse benefits must be provided through your HMO. There are no mental health or substance abuse benefits if you use a non-HMO provider.	In-Network -- All of your mental health and substance abuse benefits are provided through your HMO participating providers, and must be authorized by your HMO.	Out-of-Network
Inpatient Care, including residential crisis services	100% for up to 365 days/year if approved by the HMO	Not Covered
Outpatient Care	80% for HMO-approved outpatient visits #1-5 per calendar year; 65% for HMO-approved outpatient visits #6-30 per calendar year; 50% for HMO-approved outpatient visits #31 or more per calendar year.	Not Covered

• Consult your HMO plan for more details on covered services.

MENTAL HEALTH/ SUBSTANCE ABUSE ■

Questions?

Please call your HMO.

POS and PPO Medical Plans: If you are enrolled in a POS or PPO medical plan, your mental health and substance abuse benefits are provided by APS. To maximize your benefits, you must contact APS before receiving any services. The professionals at APS will work with you to select an appropriate referral for care. Your mental health and substance abuse benefits include coverage for the following types of treatment for mental health and substance abuse:

- inpatient facility and professional services,
- partial hospitalization, and
- outpatient facility and professional services.

Your primary care physician in the PPO or POS plan cannot treat or refer you for mental health or substance abuse treatment. You must contact APS.

Standard Mental Health and Substance Abuse Benefits Chart for Individuals Enrolled in PPO or POS Medical Plans
[Benefits administered by APS Healthcare, Inc.]

Benefit	In-Network: Care Pre-authorized	In-Network: Care Not Pre-authorized	Out-of-Network: Care Pre-authorized	Out-of Network: Care Not Pre- autho-rized	Coverage Limits
Outpatient Facility/ Office and Professional Services, including Intensive Outpatient**	80% (first 5 visits) 65% (next 25 visits) 50% (further visits) of APS's negotiated fee maxi-mum.	40% (first 5 visits) 32.5% (next 25 visits) 25% (further visits) of APS's negotiated fee maxi-mum.	40% (first 5 visits) 32.5% (next 25 visits) 25% (further visits) of APS's negotiated fee maxi-mum.	20% (first 5 visits) 16.25% (next 25 visits) 12.5% (fur-ther visits) of APS's negoti-ated fee maximum.	No limit on the number of medically necessary/ treatable visits per year. Benefit reduction if preauthorization is not obtained. No limit on out-of-pocket expenses.
* ALL PERCENTAGES REFER TO APS HEALTHCARE, INC.'S NEGOTIATED FEE MAXIMUMS. All services must be deemed medically necessary by APS Healthcare, Inc. to obtain any benefits. ** Intensive Outpatient Services (IOP) require pre-authorization regardless of in- or out-of-network provider status.					
Outpatient Medication Manage-ment Services	100% of APS's negoti-ated fee maximums after a $20 copay is met.	50% of APS's negotiated fee maximum.	50% of APS's negotiated fee maxi-mums.	25% of APS's negotiated fee maxi-mums.	No limit on the number of medically necessary visits per year. Benefit reduc-tion if preauthoriza-tion is not obtained. No limit on out-of-pocket expenses.

Benefit Chart continued on next page

MENTAL HEALTH/ SUBSTANCE ABUSE

Standard Mental Health and Substance Abuse Benefits Chart for Individuals Enrolled in PPO or POS Medical Plans (continued)
[Benefits administered by APS Healthcare, Inc.]

Benefit	In-Network: Care Pre-authorized	In-Network: Care Not Pre-authorized	Out-of-Network: Care Pre-authorized	Out-of Network: Care Not Pre- autho-rized	Coverage Limits
Inpatient Facility and Professional Services and Partial Hospitaliza-tion Services and residen-tial crisis services	100% of APS's negoti-ated fee maximums.	Not covered	80% of APS's negotiated fee maxi-mums.	Not covered	No benefit coverage if preauthorization is not obtained, regard-less of whether provider is in-network or out-of-network. Out-of-Network Expenses: co-insur-ance expenses during any one inpatient stay is limited to $1,500 per member. Member may be liable for any expens-es incurred beyond allowed amounts. No limit to medically nec-essary and treatable preauthorized inpa-tient days. Sixty days per benefit period for partial hospitalization.

* ALL PERCENTAGES REFER TO APS HEALTHCARE, INC.'S NEGOTIATED FEE MAXIMUMS
* All services must be deemed medically necessary by APS Healthcare, Inc. to obtain any benefits

- Covered charges for mental health and substance abuse are the same.
- Substance Abuse Detoxification and Rehabilitation are covered under inpatient, partial hospitalization, or outpatient services when medically necessary.
- To receive maximum benefits, care must be preauthorized by calling APS Healthcare, Inc. at 1-877-239-1458.

Questions

What should I do in the event of an emergency?

Call the APS State of Maryland dedicated Help Line at 1-877-239-1458 for immediate assistance if you are experiencing a non-life threatening emergency or crisis. If the emergency is life threatening, you should seek treatment at the nearest emergency room. You must notify APS within 24 hours of an emergency admission to certify your care. APS staff are available 24 hours a day, seven days a week, 365 days a year.

NOTE: If you obtain services without preauthorization from APS, your benefits will be reduced by 50% for medically necessary OUTPATIENT services and you will receive no benefits for INPATIENT facility and professional service costs. You receive maximum available benefits if you receive care from an APS provider that has been preauthorized by an APS team specialist at the APS Help Line, 1-877-239-1458.

What happens when I call the APS Help Line?

You will speak to a APS team member, who will work with you or your covered family member to find the resources you need or to determine the appropriate treatment for your situation. APS team members include member referral and customer service representatives, and mental health professionals experienced in dealing with mental health and substance abuse problems.

Are detoxification and rehabilitation services covered?

Yes, detoxification and rehabilitation services are covered through and administered in the same manner as mental health services.

Must I get preauthorization before benefits are paid on care I receive?

Yes, for inpatient and partial hospitalization services, you must get preauthorization care in order to be eligible for benefit coverage. To preauthorize services, you or your provider must call the **APS Helpline** at 1-877-239-1458. **APS** staff are available 24 hours a day, seven days a week.

In order to receive maximum benefits for any needed outpatient care, you or your family members must preauthorize care before services are rendered. If preauthorization is not obtained, your benefit coverage for outpatient services will be reduced.

Must I get preauthorization for pyschological testing?

Yes. Pyschological testing is an excluded service under certain circumstances, such as for educational circumstances. Thus, preauthorization must be obtained in order to determine medical necessity and plan inclusion.

Must I get preauthorization for Intensive Outpatient Program services? What is the benefit?

Yes. Intensive Outpatient Program (IOP) services require preauthorization in order to determine medical necessity for an alternative level of outpatient care. However, IOP services are covered under the outpatient benefit structure, which includes a co-insurance amount.

Can I use a non-APS provider?

Yes, you may choose to receive care from a provider not in the APS network, but please be aware of the following:

- You must call the APS Help Line for preauthorization in order to receive maximum out-of-network benefits. The APS Care Manager will discuss the case with you for preauthorization and treatment approval. **If you receive care from an out-of-network provider without preauthorization, your benefits will be reduced, and you may not have any coverage for the service.**

- You will incur greater out-of-pocket expenses when you use out-of-network providers. The State of Maryland Mental Health and Substance Abuse Benefits Chart outlines the differences between out-of-network and in-network benefits reimbursement.

- The provider you choose must be a licensed practitioner and vendor-eligible as determined by State law. It is your responsibility to verify that the provider you have chosen is appropriately licensed.

MENTAL HEALTH/ SUBSTANCE ABUSE

Will I have to file claims?

IN-NETWORK SERVICES:

If you receive preauthorized services from an in-network provider, you do not have to file any claims. If you self-refer, you may have to file a claim with an itemized bill to APS for reimbursement. Please be aware that providers may include on the bill both medical and mental health services. Medical service charges must be submitted to your medical plan, and mental health charges must be submitted to APS. Please call the APS Help Line at 1-877-239-1458 for a member claim form and further information on filing claims.

OUT-OF-NETWORK SERVICES:

How to File a Claim for Out-of-Network Services Received:

1. The provider may ask you to pay the bill at the time of service. If this happens, pay the provider and submit a claim and an itemized bill to APS for reimbursement. Call the Help Line at 1-877-239-1458 for a claim form if you do not have one.
2. The itemized bill should be on the provider's letterhead stationery and should include:
   - diagnosis and type of treatment rendered (including CPT code);
   - the charges for the services performed;
   - the date of service;
   - patient's name, patient's date of birth and subscriber's Social Security number.
3. Mail your completed information to:
   APS Healthcare, Inc.
   SOM Claims
   P.O. Box 1440
   Rockville, MD 20849-1440
4. APS will send the payment for covered services directly to the subscriber address in the BAS system. You will also receive an Explanation of Benefits (EOB) any time APS processes a claim. An EOB is not a bill: it is documentation of the action APS has taken on your claim.

May I use the EAP, even though I am enrolled in an HMO medical plan?

Yes. The EAP is a service available to all State employees, regardless of medical plan enrollment. You must be referred by your supervisor for EAP services. Employees cannot self-refer for this service.

Other Questions?

If you have any more questions concerning coverage, exclusions, or limitations, please contact APS at the phone number listed on the back cover of this book.

Exclusions:

The following is a list of excluded services. APS does not cover services and supplies:

• that are not preauthorized and medically necessary;

• not prescribed, performed, or guided by eligible practitioners;

• for inpatient treatment (or for an inpatient stay) for conditions that require only observation, diagnostic examinations, or diagnostic laboratory testing;

• for inpatient treatment that might be safely and adequately rendered in a home, provider's office, or at any lesser level of institutional care;

• that APS determines are experimental or investigative in nature or for services related to them. Experimental or investigative describes any service or supply that is judged to be experimental or investigative by APS in its sole discretion. APS will apply the following criteria to decide this: any supply or drug used must have received final approval to market by the U.S. Food & Drug Administration; there must be enough information in the peer-reviewed medical and scientific literature to let APS judge the safety and efficacy; the available scientific evidence must show a good effect on health outcomes outside of a research setting; the service or supply must be safe and effective outside a research setting as current diagnostic or therapeutic options; for lab tests and prescription drugs;

• when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons;

• for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;

• charged through separate billings by a provider's employee normally included in such provider's charges and billed for by them;

• provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner;

• that are a part of a hospital, facility, or institutional stay if the patient is discharged and readmitted to the hospital, facility, or institution within 14 days in order to qualify for insurance coverage where the patient was not previously covered;

• for travel whether or not it is prescribed by a practitioner;

• for guest meals, telephones, televisions, and other convenience items;

• for routine examinations or testing;

• for the treatment of any injury, illness, or medical condition that is not medically necessary;

• for illnesses resulting from an act of war or relating to the commission of a felony;

• for treatment of organic brain syndrome;

• for acupuncture;

• for examinations of an inpatient that are not related to the diagnosis;

• for educational or teacher's services, or separate charges by interns, residents, house physicians, or other health care professionals employed by the covered facility;

• for smoking cessation;

• for weight loss and weight management programs;

• for court-ordered treatment (unless medically necessary);

• for psychoanalysis to complete degree or residency requirements;

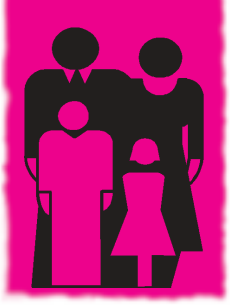
• for experimental treatment or treatment performed for the purposes of research;

• for marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;

• for pastoral counseling;

• for psychological testing for education purposes;

• for residential services, except crisis residential services covered by House Bill 896 and must be pre-authorized by APS.



TERM LIFE

TERM LIFE INSURANCE PLAN

General Description of Coverage

The Term Life Insurance Plan is available to all employees and their dependents who are eligible for health benefits with the State. Employees are eligible for coverage in $10,000 increments to a maximum of $300,000. Standard Insurance Company provides life insurance coverage for State employees and eligible dependents, effective January 1, 2003.

You may choose up to $50,000 in coverage without a Medical History Statement. If you select greater than $50,000 for yourself or $25,000 for your dependent, you must complete and submit the Medical History Statement, which will be reviewed for approval by the plan. Medical History Statements are available from your Agency Benefits Coordinator.

Accelerated Benefit: An Accelerated Benefit is available in the event of a terminal illness. An insured employee (or insured spouse) has the option for early access to up to 50% of the face amount of their insurance coverage, if the insured person is medically certified to be terminally ill with less than six months to live, and has at least $20,000 in coverage.

Dependent Life Insurance Coverage: Employees can elect dependent life insurance coverage up to 50% of the employee's coverage. The employee must enroll for at least $10,000 in Employee Life Insurance coverage to be eligible for Dependent Life Insurance coverage. Certain other rules apply to dependent coverage:

- Dependent life insurance coverage is available (in $5,000 increments), up to $150,000 in coverage. Employees can obtain dependent life insurance for a spouse and/or child(ren).
- Dependent life insurance coverage is available up to $25,000 without Medical Review. If you elect a higher amount of coverage, you must complete the Medical History Statement for the dependent, to be reviewed for approval by the plan. Applications for the Medical History Statement are available from your Agency Benefits Coordinator. You may also be notified by the plan to complete an additional Medical History Statement.
- The Accelerated Benefit is available for a terminally ill spouse. The spouse must be insured for at least $20,000 to be eligible for the Accelerated Benefit option.

Retirement: State Employees who retired after January 1, 1995 and were enrolled in the Term Life Insurance Plan as active employees have the opportunity to continue their group life insurance coverage at the time of retirement, if they are eligible to participate in State health benefits upon retirement, subject to the age reduction schedule below. Certain other rules apply when an employee retires. A Beneficiary Designation form should be on file with the plan.

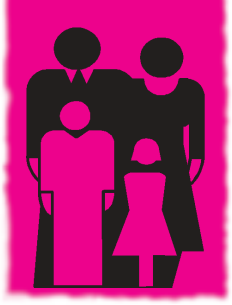
- Benefits will automatically decrease with age from the original amount according to the schedule shown below.

Automatic Reduction of Benefits: If life insurance is continued into retirement, benefits for retirees, their spouse and dependents will automatically reduce from the original amount at the percentages listed below and based upon the retiree's attained age.

- 65% at age 65
- 45% at age 70
- 30% at age 75
- 20% at age 80

NOTE: Premiums are adjusted according to the reduced coverage. Coverage for a Spouse and Dependents will reduce as well.

- You cannot increase your life insurance coverage in retirement.
- You can cancel your enrollment in the Term Life Insurance Plan. However, retirees who cancel their enrollment in the life insurance plan cannot re-enroll.



Continuation of Coverage During Total Disability: After January 1, 2004, if you become totally disabled prior to age 60 and are enrolled in the State term life insurance plan on your date of disability, your coverage will continue until the ninth month of your total disability. At the ninth month, you must submit a Waiver of Premium application to the plan. If approved, your coverage will continue to age 65 or until you are no longer disabled and premiums will be waived. If declined, your only option for continuation of coverage is to convert to an Individual policy. Conversion applications are available from your Agency Benefits Coordinator or from the plan. Please note, Waiver of Premium applications will NOT be accepted beyond twelve months from your date of disability.

Waiver of Premium with MetLife: The former Life Insurance plan was with The Metropolitan Life Insurance Company (Met Life) until December 31, 2002. However, if you have a waiver of premium with The Metropolitan Life Insurance Company, your coverage under the waiver continues with Met Life.

** Your Waiver of Premium coverage will continue with Met Life until the month you reach age 65 under the same terms and conditions. You may then convert to an Individual policy with Met Life. You do not transfer over to the The Standard.

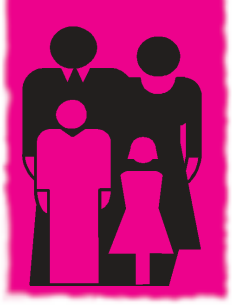
NOTE: You cannot have duplicate coverage under the life insurance plan. If you are covered as an employee, you cannot also be covered as a dependent of your spouse. If a husband and wife are both employed by the State, only one of the employees can cover dependent children, and they cannot cover each other with duplicate policies. Also, children of State employees cannot have duplicate coverage. The Standard will only pay benefits in accordance with one policy.

How to Receive Term Life Insurance Benefits

The Term Life Insurance Plan pays out 100% of the face amount of coverage upon the death of an active employee or an insured dependent. The Term Life Insurance Plan also has an Accelerated Benefit provision that allows early access to up to 50% of the face amount of coverage if the insured employee or spouse is medically certified to be terminally ill, with less than six months to live. The insured employee or spouse must be insured for at least $20,000 to be eligible for the Living Benefit option. The named beneficiary should contact the plan in order to obtain a claim form.

Changing Coverage after Enrollment: If you are currently enrolled in the Plan, you may continue with the plan at your current coverage level each plan year without Medical Review. If you want to increase your coverage to more than $50,000 during Open Enrollment, regardless of your current coverage amount, you must file a Medical History Statement with the plan. Applications are available from your Agency Benefits Coordinator. Please note that your increased coverage amount will become effective on the latter of: January 1, the date Standard Insurance Company approves your medical review, or the date you become "actively at work." Please note that if you drop a dependent from your coverage, it includes all coverages, including life insurance. New employees have 60 days from their entry on duty date to enroll in the plan.

NOTE: For your State Term Insurance benefits coverage to begin after a new enrollment, you must be "actively at work," in the employ of the State of Maryland, and performing services for compensation on regularly scheduled working days. Regularly scheduled working days do not include holidays, non-work days, vacations, or other scheduled leaves. "Actively at work" means that you have worked at least 20 hours over the last seven consecutive calendar days and have worked at either your usual place of employment or away from your usual place of business at the agency's convenience, and that you are not currently on sick leave or other type of scheduled leave.



TERM LIFE

Conversion and Portability of Coverage: An active employee leaving State service has the option under "Portability" to continue their current coverage, along with their dependent coverage, by directly paying the plan. Conversion to a personal policy is available within 31 days of loss of coverage with the group policy. Please call the plan representative at the phone number listed on the back cover for information on conversion to non-group policies.

Beneficiaries: The Standard requires a valid Standard Insurance Company Beneficiary Designation Form.

MetLife Beneficiary designations from the former life insurance plan are no longer valid. The Standard requires a valid Standard Insurance Company Beneficiary Designation on file. If you do not execute a Life Insurance Beneficiary Designation Card for The Standard, your life insurance benefits will be distributed according to the order described detailed in your Standard Insurance Company Voluntary Life Insurance Employee Booklet. If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the following classes: 1. Your Spouse, 2. Your Children, 3. Your Parents, 4. Your Brothers and Sisters, or 5. Your Estate. Please see your Agency Benefits Coordinator for a Standard Insurance Company Beneficiary Designation Form. The Policy number for The Standard is #642220.

Questions?

If you have any questions about coverage, conversion policies upon termination of employment, limitations, definitions, restrictions, terminating events, or exclusions, please call the plan at the number located on the back cover of this book.

PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

General Description of Coverage

The Accidental Death and Dismemberment (AD&D) Plan is available to all active status employees and their dependents who are eligible for health benefits with the State through the Metropolitan Life Insurance Company (effective January 1, 2003). The Plan provides benefits in the event of an accidental death or dismemberment. You can choose either Employee Only coverage, or Employee and Family Coverage at one of three principal benefit amounts. The Metropolitan Life Insurance Company refers to their plan as the Voluntary Accidental Death & Dismemberment Plan (VAD&D).

Medical Review: No medical review is required for enrollment in the Plan. This Plan will cover you for accidents that occur at work as well as accidents off-the-job.

Additional Benefits: The AD&D Plan has many other benefits in the event of a covered loss. Please contact your Agency Benefits Coordinator to review the plan booklet containing a detailed description of the additional benefits. Additional benefits include:

- Exposure and Disappearance
- Waiver of Premium
- Education
- Day Care
- Seat Belt
- Common Disaster
- Emergency Evacuation
- Repatriation of Remains

Exclusions: The Plan does not cover any losses caused by or resulting from: (1) physical or mental illness, diagnosis of or treatment for the illness of, or (2) an infection, unless caused by an external wound that can be seen and which was sustained in an accident, or (3) suicide or attempted suicide, or (4) injuring oneself on purpose, or (5) the use of any drug or medicine, or (6) a war or a warlike action in time of peace, including terrorists acts, or (7) committing or trying to commit a felony or other serious crime or an assault, or (8) any poison or gas voluntarily taken, administered or absorbed, or (9) service in the armed forces or any country or international authority, except the United States National Guard, or (10) operating, learning to operate, or serving as a member of a crew of an aircraft, or (11) while in any aircraft operated by or under any military authority (other than Military Airlift Command), or (12) while in any aircraft used or designed for use beyond the Earth's atmosphere, or (13) while in any aircraft being used for a test or experimental purposes, or (14) while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation), or (15) driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

ACCIDENTAL DEATH & DISMEMBER-MENT

How to Receive AD&D Plan Benefits

Benefits will be paid to the Insured Person within 365 days of the date of an accident. The Plan will pay, in one sum, a certain percentage of the Principal Benefit Amount, depending on whether there is a loss of life or some type of dismemberment. If more than one covered loss is sustained during one accident, the Plan will pay all losses up to the Principal Sum Amount.

Questions?

If you have any questions concerning coverage, limitations, or exclusions, please contact the plan at the phone number listed on the back cover of this book.

Employee Standard Benefits Chart for AD&D Plan

Loss of	Benefit
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing (both ears)	100%
Quadriplegia	100%
Paraplegia	75%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Speech or Hearing	50%
Hemiplegia	50%
Thumb and Index Finger of Same Hand	25%

If you choose Family coverage, benefits for your spouse and eligible dependent children are as follows:

Standard Dependent Benefits Chart for AD&D Plan

Dependent	Benefit
Spouse -and- Eligible Dependent Child(ren)	55% of Insured Employee's Principal Benefit Amount -and- 15% of Insured Employee's Principal Benefit Amount
If no Spouse	* Eligible Dependent Child(ren) receive 25% of Insured Employee's Principal Benefit Amount
If no Eligible Dependent Child(ren)	Spouse receives 65% of Insured Employee's Principal Benefit Amount

* Maximum benefits available per child is $50,000.

NOTE: Please contact MetLife at the telephone number listed on the back cover of this book for an AD&D Beneficiary Designation Form. You must complete an updated AD&D Beneficiary Designation Form for the AD&D carrier, MetLife.

FLEXIBLE SPENDING ACCOUNTS

General Description of Flexible Spending Accounts

Using a Flexible Spending Account can save most employees 22% to 38% of the cost of eligible out of pocket expenses for health and day care services. Each part of a Flexible Spending Account has special advantages and restrictions. You should read this section carefully. **You may want to discuss your personal situation with a tax advisor before deciding how to make a Flexible Spending Account work for you.** The State Flexible Spending Accounts are administered by **Erisa Administrative Services, Inc.**

NOTE: When you enroll in a Flexible Spending Account, you will be electing the amount per pay period regardless of the enrollment method used. There is no way to select your annual maximum. Refer to the "How to Enroll" section in this book.

Questions

What is a Flexible Spending Account?
A Flexible Spending Account takes advantage of income tax laws that allow you to pay your share of the cost of your benefits on a tax-free basis. Through a Flexible Spending Account, you "redirect" part of your pay before federal income or Social Security taxes are computed.

With a Flexible Spending Account, you don't pay federal income taxes, state income taxes or Social Security taxes on the money you use.

$1,700 Total Monthly Taxable Salary	−	**$200** Flexible Contribution	−	**$340** Taxes (Estimated)	=	**$1,160** Take-Home Pay

Without a Flexible Spending Account, you are paying taxes on the money you use for eligible expenses. Why pay taxes on this money if you don't have to?

$1,700 Total Monthly Taxable Salary	−	**$385** Taxes (Estimated)	−	**$200** Expenses Paid After Taxes	=	**$1,115** Take Home Pay

In this example, you save $45 per month or $540 per year in federal income and Social Security taxes by using a Flexible Spending Account.

How Flexible Spending Accounts Work:
Flexible Spending Accounts offer two ways to pay certain expenses with tax-free dollars.
* Health Care Flexible Spending Account
* Day Care Flexible Spending Account

Will a Flexible Spending Account affect my State of Maryland retirement benefits?
Your State retirement benefits are based on your salary before a Flexible Spending Account redirection.

FLEXIBLE SPENDING ACCOUNTS

Will a Flexible Spending Account affect my Group Life, Disability, and other benefits?
No, benefits for Term Life, Short and Long Term Disability, and other benefits will be based on your salary before a Flexible Spending Account redirection.

Will a Flexible Spending Account affect any other State benefit?
It may affect the amount to be directed to your deferred compensation plan. Check with your tax advisor and/or your Agency Benefits Coordinator.

You may wish to consider contributing all or a portion of your Flexible Spending Account savings to a deferred compensation plan to offset any reduction in Social Security benefits or to reduce your Flexible Spending Account participation as you near retirement.

Health Care Flexible Spending Account (HFSA)

What is a health care flexible spending account?
A health care flexible spending account (HFSA) allows you to set aside tax-free money to cover eligible health care expenses you incur for you and your eligible dependents during the plan year. To be considered a "dependent," the person must meet the IRS definition of dependent.

Using tax-free dollars to pay for eligible expenses: With the HFSA, you can set aside money to cover eligible health care expenses on a tax-free basis. This way, you save money because you never have to pay taxes on the money you set aside in the account.

Eligible health care (medical) expenses: Eligible health care (medical) expenses are expenses which are "**medically necessary.**" This means the expenses must be for the diagnosis, treatment or prevention of disease and for treatment affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness.

In addition, to qualify as a reimbursable health care expense the medical, dental, vision or hearing expense must:

* be incurred (received) during your eligible period of coverage January 1- December 31 of the plan year or dates of active employment status (please be aware that the incurred date for dental services is the impression date and that prescriptions are based upon the fill date); and
* not be reimbursable from any other health insurance.
* if you have any insurance benefits, you must use them before you obtain reimbursement from your HCSA.

Expenses incurred prior to or after the end of the plan year or after your eligible period of coverage (dates of active employment status) are not reimbursable.

NEW! Some non-prescription Over-The-Counter (OTC) drugs can be reimbursed:

The Internal Revenue Service issued a ruling allowing the reimbursement of some OTC drugs from your HFSA. Types of reimbursable expenses include: antacids, allergy medicines, pain relievers, cold medicines. Non-reimbursable expenses include: vitamins, herbs, toiletries, cosmetics, sundry (non-drug) items. To request reimbursement, the receipt must have the following information: 1) the name of the OTC medicine or drug; 2) the name of the eligible family member/members that the OTC medicine or drug was purchased for; 3) the date that the OTC medicine was purchased; and 4) the name of the store/pharmacy where the OTC medicine was purchased. (Effective 1/1/04)

Expenses (those of yourself and your dependents) that can be reimbursed: These are medically necessary and generally covered by your health insurance carrier. Some of the expenses that may be eligible for reimbursement through the HFSA if they are not paid by insurance include:

- Co-insurance and deductibles
- Physicals
  - Routine and preventive physicals
  - School and work physicals
- Vision Care
  - Ophthalmologist or Optometrist fees
  - Eyeglasses
  - Contact Lenses
  - Laser Surgery
- Hearing care
  - Hearing aids and batteries
- Prescription drugs
  - Exclude prescription drugs for cosmetic purposes only
- Dental and orthodontic care
  - Most dental care
  - Braces, orthodontic devices necessary for proper function of the body (Reimbursement of orthodontic care is prorated over the term of the orthodontic contract or treatment plan; submit a copy of the orthodontia service contract at the beginning of every plan year.)
- Psychiatrist
- Psychoanalyst (medical care only)
- Psychologist (medical care only)
- Treatment for Alcoholism or drugs
- Sterilization
- Acupuncture
- Vaccinations
- Physical therapy
- Speech therapy
- Transportation essential to medical care (proof of mileage and medical cure required; contact Erisa for details.)
- Ambulance service
- Bus, train, taxi or plane fare
- Fees to doctors, hospitals, etc. for:
  - Anesthesiologist
  - Chiropractor
  - Christian Science practitioners
  - Dermatologist
  - Neurologist
  - Obstetrician
  - Pathologist
  - Pediatrician
  - Podiatrist
- Oxygen equipment
- Wheelchair
- Weight Loss Programs
  - Initiation fees and weekly meetings; must have physician diagnosis of medical problem
- Radiologist - X-rays
- Some non-prescription over-the-counter drugs, including antacids, allergy medicines, pain relievers, cold medicines

Expenses that cannot be reimbursed: Expenses that are for general health or personal improvement, even if prescribed or recommended by your physician, **cannot be reimbursed.**

- Cosmetic surgery such as facelifts and liposuction
- Some prescription drugs, even if prescribed by a physician:
  - Rogaine or other growth drugs
  - Retin A or other drugs for cosmetic use
  - Other drugs for general health and not for specific medical care
- Fees for exercise, athletic, or health club membership even if prescribed by a physician
- Health insurance premiums
- Amount paid for by a separate medical plan
- Humidifier purchased for dust allergy
- Health club/Swimming pool dues, fees for exercise or health club membership even if prescribed by a physician
- Expenses of divorce, even when doctor or Psychiatrist recommends divorce
- Wellness or self-improvement classes
- LAMAZE
- Maternity clothes
- Diaper Service
- Ear piercing or Tatooing
- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased for dust allergy
- Humidifier purchased for dust allergy
- Massage Therapy for non-specific injury/illness
- Counseling Services:
  - Interpersonal relationship counseling,
  - Marriage counseling, family therapy (unless by a medical practitioner with a medical diagnosis)
- Dietary Foods and Vitamins

Please contact Customer Service at Erisa Administrative Services at 1-888-966-3539 to check eligibility of a procedure or expense. The IRS regulations do not permit the claim administrator to accept cancelled checks or cash register receipts as documentation of an expense.

FLEXIBLE SPENDING ACCOUNTS

Who is eligible to participate in an HFSA?
You are eligible to participate in an HFSA if you are otherwise eligible for health benefits with the State. Seasonal, temporary and contractual employees and graduate students are not eligible for HFSA.

Duration of participation: An election to participate or not to participate in an HFSA is irrevocable for the plan year unless you have an eligible change in family status. Complete the Flexible Spending Account section of the Enrollment Worksheet on the date the change in family status occurs or within 60 days of the qualifying event. Your eligibility is governed by the effective dates of coverage as outlined in this book.

HOW TO ENROLL

During the Open Enrollment period — if you wish to enroll in an HFSA, you must use the IVR system. If prompted by the IVR that you are not able to use this enrollment method, you must complete and file an Enrollment Worksheet before Open Enrollment ends.

After the start of the plan year — If you become eligible after the start of a new plan year, you may enroll on your date of eligibility (date of hire) or within 60 days of the qualifying event. After the qualifying event, complete and file an Enrollment Worksheet with your Agency Benefits Coordinator within 60 days. Your effective date of new coverage or a change in coverage depends upon when your payroll deductions start or change. You cannot do a Retroactive Adjustment for the Health Care Flexible Spending Account benefit. Only those eligible expenses incurred after the effective date of your enrollment in the HFSA may be reimbursed.

Setting up an account: You decide how much money to set aside in an account for the plan year. You may deposit any amount between $120 to 3,000 annually for a full Plan year.

Health Care FSA:	Minimum	Maximum
Annually	$120.00	$3,000.00
12 pay period deductions	$10.00	$250.00
24 pay period deductions	$5.00	$125.00
21 or 22-Pay-Faculty (19)* Scheduled Deductions	$6.32/pay	$157.89/pay

* **For Year 2004, all 21 or 22-Pay Faculty members must contact the Personnel Office of their respective institutions for a Year 2004 schedule of paychecks and multiple deductions. Multiple deduction schedules differ by institution.**

After you decide how much money you want to set aside in the HFSA, complete the Flexible Spending Account section of the Enrollment Worksheet. **The amount you authorize per pay period will be redirected, before taxes, from your paycheck.**

Estimate your expenses on the conservative side: Estimating your expenses conservatively will allow you to benefit from the HFSA's tax advantage without having to forfeit any portion of your account that is not used by the end of the plan year or your period of active status employment.

Use it or lose it (forfeiture): Because of the favorable tax treatment you receive through this type of account, there is an IRS restriction that applies. The restriction states that any money remaining in your HFSA at the end of the grace period will be forfeited.

NOTE: Medical expenses that are reimbursed through your HFSA cannot be deducted on your personal income tax return.

Using your account — filing claims: As you incur reimbursable health care expenses (for yourself and your dependents) during your eligible period of coverage, send in your claim forms and the required documentation to the claim administrator listed on the claim form. When you have claimed $20 or more in unreimbursed expenses (for example: deductibles, coinsurance, or expenses not covered by insurance), a benefit payment from your account will be sent to you, either by check or direct deposit. After the end of the last quarter of the plan year, claims for less than $20 will be paid.

How often are claims paid?
Claims are processed weekly for payment. Claim requests will be processed within 10 days of receipt.

Required claim reimbursement documentation:

Include this with your claim.

- A completed (and signed) Healthcare Claim Form; and
- Explanation of Benefits (EOB) from the insurance companies in which you are enrolled. File your claim with your insurance plan first, even if you know it will not be covered. Then submit the Explanation of Benefits or denial with your claim form. This includes your vision, dental, and mental health/substance abuse claims. You may file an HFSA claim for the portion that you are required to pay after insurance reimbursement.
- Prescription receipts should include the name of the patient, the name of the prescribing physician, the name of the drug, the date the prescription was filled, the prescription number, and the charge to the patient. The copay amount should be indicated on the receipt.
- Receipts for in-network medical copays should include the name of the patient, the name and address of the doctor, the date of service, the ADA code, and the amount the patient owes for each service. Out-of-network and out-of-area dental claims must be filed with insurance first. Send the Explanation of Benefits or denial with your claim form.

Incomplete or incorrect documentation will delay processing of claims. Instructions for completing the HFSA claim form are provided on the claim form itself. For convenience, you may download a claim form at the website on the back of the book.

Claim filing grace period: The claim filing grace period is January through April 15, following the close of the plan year. Claims for Year 2004 must be postmarked no later than April 15, 2005 in order to be reimbursed.

Claims for Year 2004 received in April 2005 must be complete and correct or they will not be processed for payment or returned to you. File your claims for Year 2004 no later than March 15, 2005 to allow sufficient time to submit missing or correct documentation.

Keeping track of your account: To help you keep track of your account, you will receive a quarterly statement. This statement will show the activity in your account and keep you informed about your remaining balance. You may check your account balance and benefit payments on the website or on the voice computer by calling 1-888-237-9141.

Making changes during the plan year: An eligible change in family status (including gaining a dependent through marriage, birth, adoption or gaining legal custody of a child) will permit you to change your HFSA election amount, if the change is consistent with the change in family status.

If you wish to change your election amount, see your Agency Benefits Coordinator to complete and file an Enrollment Worksheet on the date the change in family status occurs or within 60 days of the qualifying event. A change in family status will require documentation (for example: marriage license, birth certificate) for verification of the event.

FLEXIBLE SPENDING ACCOUNTS

If the HFSA is for you, here's what you can do:
* See your Agency Benefits Coordinator, and enroll.
* Keep this booklet for future reference.

Day Care Flexible Spending Account (DCFSA)

One of the most important issues to a working parent is child care. Not only is it difficult to find and arrange for good child care, it can be very expensive. Also, with our aging population, many people are caring for elderly or disabled dependents who are unable to care for themselves.

What is a Day Care Flexible Spending Account?
The Day Care Flexible Spending Account (DCFSA) is designed to give you a tax saving way to pay for day care expenses for your children or eligible dependents.

It is important to remember that day care expenses must meet certain IRS requirements. The expenses must be necessary for you to continue working. If married, you and your spouse must both be working, or your spouse must be a full-time student or disabled.

To be considered a "dependent," the person receiving care must be eligible to be claimed as your dependent on your federal income tax return and be either:
* under age 13; or
* your spouse or other dependent who is physically or mentally incapable of self-support, and who spends at least 8 hours per day in your home.

Using tax-free dollars to pay for expenses: With a DCFSA you can set aside money to cover these expenses on a tax-free basis. This way you save money because you never have to pay taxes on the money you set aside in the account. For example, if you incur $2,000 of eligible day care expenses in a year, you could save about $453 in federal income taxes and FICA taxes:

With A Flexible Spending Account		Without A Flexible Spending Account
$ 45,000	Salary	$ 45,000
− 2,000	Pretax Child Care	0
43,000	Taxable Income	45,000
− 9,740	Taxes*	− 10,139
33,260	After-Tax Income	34,807
0	After-Tax Child Care	2,000
$ 33,260	Take-Home pay	$ 32,807

This employee saved $453 in Federal taxes by participating in a DCFSA!

***This example assumes a 15% tax bracket, 7.65% FICA taxes and does <u>not</u> include Day Care Tax Credit**

FLEXIBLE SPENDING ACCOUNTS

Reimbursable day care expenses: To qualify as a reimbursable day care expense, the expense must be incurred during the plan year. Any day care expenses incurred prior to or after the plan year or outside the period of active status employment are not reimbursable.

Expenses that can be reimbursed: The following examples of expenses can be paid through your DCFSA. Remember, these expenses must meet IRS requirements, and they must be necessary for you and, if married, your spouse to continue working:

* child day care services inside your home or someone else's home
* charges by a licensed day care facility
* adult day care inside your home or someone else's home
* expenses for summer day camp

NOTE: Do not include your dependents health (medical) care expenses in your DCFSA. Dependents health care expenses are to be included in your Health Care Flexible Spending Account.

Expenses that cannot be reimbursed: The following are expenses that do not qualify for reimbursement:

* day care expenses you claim on your federal income tax return (child care credit)
* child care or babysitting services by your spouse or by someone you claim as a dependent on your federal income tax return
* housekeeping expenses not related to day care
* food or clothing expenses for a dependent
* transportation expenses between your home and the place your dependent receives care
* Kindergarten expenses and tuition costs for school-aged children
* Charges more than 30 days in advance of the service
* Expenses for overnight camp

The IRS regulations do not permit the claim administrator to accept cancelled checks or cash register receipts as documentation of an expense.

Who is eligible to participate: You are eligible to use a DCFSA if you are an active full-time employee. Seasonal and temporary employees and graduate students are not eligible for the DCFSA.

Duration of participation: An election to participate or not to participate in the DCFSA is irrevocable for the plan year, unless you have an eligible change in family status and complete the Flexible Spending Account section of the Enrollment Worksheet within 60 days of the qualifying event.

HOW TO ENROLL

During the Open Enrollment period — If you wish to enroll in a DCFSA, you must use the IVR enrollment system. If prompted by the IVR that you are not able to use this enrollment method, you must complete and file an Enrollment Worksheet before Open Enrollment ends. You cannot do a Retroactive Adjustment for the Day Care Flexible Spending Account benefit.

After the start of the plan year —

* If you are a new employee or you are returning to work from leave without pay after the start of a plan year, you will have 60 days from the date of employment or return to work with the State to enroll in a DCFSA.
* If you become eligible for a DCFSA as the result of a change in family status, you have 60 days after the date the change in family status occurs to enroll in the day care account.

Your effective date of new coverage or a change in coverage depends upon when your payroll deductions start or change.

FLEXIBLE SPENDING ACCOUNTS

Important tax information:

* Before making your decision about setting up a DCFSA, remember you may be able to claim a tax credit for day care expenses on your federal income tax return.
* Your personal financial and tax situation will help determine which of the two alternatives is best for you.
* In general, if your family's taxable income (after deductions) is about $24,000 a year or less, you may find that the federal income tax credit will save you more money. On the other hand, if your family's taxable income (after deductions) is more than about $24,000, you may benefit using the DCFSA. You should seek additional tax advice.
* It is possible to claim some part of the day care credit if not all of your day care expenses are paid through your DCFSA. However, the dollar limit of the expenses eligible for the credit is reduced dollar for dollar by all payments from your DCFSA.
* You should seek additional financial and tax advice before deciding which alternative is best for you. More information is available in Internal Revenue Service Publication 503, "Child and Day Care Credit."

Setting up an Account: To set up a DCFSA, you must first decide how much money to set aside for the plan year. You may deposit any amount between $120 to $5,000 annually for a full plan year. The maximum amount you may set aside in a DCFSA is half these amounts, if you are married filing a separate income tax return. The IRS limits the amount of money you may redirect to the smallest of:

* your income,
* your spouse's income, or
* $5,000 per family ($2,500 if married filing separate return).

There are special IRS provisions if your spouse is a full-time student or is disabled.

After you decide how much you want to set aside in your DCFSA complete the Flexible Spending Account section of the Enrollment Worksheet. The amount you authorized will be redirected, before taxes, from each paycheck based on the chart below:

Day Care FSA:	Minimum	Maximum
Annually	$120.00	$5,000.00
12 pay period deductions	$10.00	$416.67
24 pay period deductions	$5.00	$208.33
21 or 22-Pay Faculty (19)* Scheduled Deductions	$6.32/pay	$263.15/pay

***For Year 2004, all 21 or 22-Pay Faculty Members must contact the Personnel Office of their respective institutions for a Year 2004 schedule of paychecks and multiple deductions. Multiple deduction schedules differ by institution.**

Estimate your expenses on the conservative side: Estimating your expenses conservatively will allow you to benefit from the DCFSA's tax advantages without having to forfeit a portion of your account that may not be used by the end of the plan year or during active status employment.

Use it or lose it: Because of the favorable tax treatment you receive through this type of account, there is an IRS restriction which states that any money remaining in your account at the end of the grace period will be forfeited.

Using your account — filing claims:
As you incur reimbursable day care expenses, send in your claim forms and required documentation to the claim administrator listed on the claim form. See the claim form for more details.

When you have claimed $20 or more in eligible day care expenses, a benefit payment from your account will be sent to you. After the end of the last quarter of the plan year (December), unpaid claims of less than $20 will be paid.

How often are claims paid?
Claims are processed weekly for payment. Claim requests will be processed within 10 days of receipt.

When your claim is more than your account balance: Your DCFSA is funded on a "pay-as-you-go" basis. You may only draw on funds you have accumulated in your account. If the amount of your claim is more than the balance in your account, you will receive the balance in your account. The remainder of the expense will be "pended" while your account balance builds up from subsequent paycheck deposits. As deposits are made each pay cycle, you will be reimbursed until the claim is paid in full (assuming the total amount you elected for the year is enough to pay the claim).

Claim filing grace period: The claim filing grace period is January 1 through April 15, following the close of the plan year. Claims for Year 2004 must be postmarked no later than April 15, 2005 in order to be reimbursed.

Claims for Year 2004 received in April, 2005 must be complete and correct or they will not be processed for payment or returned to you. File your claims for Year 2004 no later than March 15, 2005 to allow sufficient time to submit missing or correct documentation.

Required claim reimbursement documentation: A completed, signed, and dated Day Care Reimbursement Claim Form. Your day care provider may complete Section IV of the claim form, including signature and date. If your day care provider does not complete Section IV of the claim form, submit a receipt for the services. The receipt should include the name, address, and taxpayer identification number of the provider, the dates of service, the charge for the service, and the name of the child(ren) for whom the services are provided.

Incomplete or incorrect documentation will delay processing of claims. Instructions for completing the Day Care Reimbursement forms are on the form itself. For convenience, you may download a claim form at the website on the back of the book.

Keeping track of your account: To help you keep track of your account, you will receive a quarterly statement. This statement will show the activity in your account and keep you informed about your remaining balance. You may check your account balance and benefit payments on the website or by calling ERISA.

Making changes after the start of a plan year: An eligible change in family status will permit you to make a change to your DCFSA election or election amount, if the change is consistent with the change in family status. Below are some examples of eligible changes in family status under the DCFSA:

* You or your spouse go to or from full-time/part-time to part-time/full-time work.
* You gain dependents through marriage, birth or the adoption of a child, or gain legal custody of a child.
* You lost dependents through divorce, death of spouse or child, or lost legal custody of a child.
* Your spouse loses or gains employment.

FLEX MARYLAND
HEALTHCARE REIMBURSEMENT CLAIM FORM

(Please complete this ENTIRE form)

SECTION I: Employee Data—Complete ALL items

Employee name (Last, First, M.I)	Social Security Number	
Mailing Address (Street Number/P.O. Box)	☐ Check here if address has changed since last claim)	
City	State	ZIP Code

Employment Status (Check One):
- ☐ Active
- ☐ Leave Without Pay as of:
- ☐ Terminated as of

SECTION II: Employee Certification

Total Number of Invoices / EOB's attached: _____

Estimated Total Reimbursement Amount: _____

Complete the information below. Refer to your Maryland Benefit Guide book for ineligible expenses.

SECTION III: INSURANCE INFORMATION Please Print

Employee's Medical Plan

Employee's Dental Plan

Spouse's Medical Plan

Spouse's Dental Plan

SECTION IV: Employee Certification (Read carefully; then date and sign this form.)

I certify that the attached charges are eligible health care expenses under the Internal Revenue Code, that these charges have been incurred, and that I have not been reimbursed nor are these charges reimbursable by any other source. I also certify that I will not claim these charges as a credit on my personal income tax return. I understand that failure to **submit** claims with required documentation by April 15th following the close of the Plan Year will result in my claims not being paid and I will lose any money left in my account. **Claims must be postmarked by April 15th or received by Erisa Administrative Services by April 15th.**

_____ _____

Date of Signature Employee Signature

Mail or fax this form to:

FLEX MARYLAND
Erisa Administrative Services, Inc.,
12325 Hymeadow Drive, Building 4-200
Austin, TX 78750
Phone: (512) 249-6710

Toll free 1-888-966-FLEX (3539) **Toll Free Fax 1-888-329-8711**

FLEX MARYLAND
DAY CARE REIMBURSEMENT CLAIM FORM

SECTION I: Employee Data—Complete ALL items		
Employee name (Last, First, M.I)	Social Security Number	
Mailing Address (Street Number/P.O. Box)	☐ Check here if address has changed since last claim)	
City	State	ZIP Code

SECTION II: Employee Certification (Read, sign, and date)

Read this section carefully, sign and date this form.
I certify that the charges on this form are eligible day care expenses under the Internal Revenue Code, that these charges have been incurred, and that I have not been reimbursed by any other source for these charges. I also certify that I will not claim these charges as a credit on my personal income tax return and that they do not exceed the maximum reimbursement permitted under the Internal Revenue Code. I understand that failure to **submit** claims with required documentation by April 15th following the close of the Plan Year will result in my claim not being paid and I will lose any money left in my account.
Claims must be postmarked by April 15th or received by Erisa Administrative Services by April 15th.

Employee Signature	Date Signed

SECTION III: Dependent Data

Enter the name(s) of the dependent(s) receiving the day care services:

Name of Dependent (Last, First, MI)	D.O.B.	Relationship to Employee
1.		
2.		
3.		
4.		

SECTION IV: Day Care Expenses and Reimbursements

1. Total amount paid to Day Care Provider:	$

2. For services rendered:
Beginning Date _____ through Ending Date _____

☐ **Attached is my itemized receipt from the service provider**

☐ This claim form is my receipt. My day care service provider has signed and dated this form to verify the dates of service and payment amount.

Name of Day Care Provider:	
Mailing address of Day Care Service Provider:	
City, State ZIP Code	
Social Security or Tax ID Number:	

Signature of Provider	Date

Mail or fax this form to:
FLEX MARYLAND
Erisa Administrative Services, Inc.,
12325 Hymeadow Drive, Building 4-200
Austin, TX 78750
Phone: (512) 249-6710

Toll free 1-888-966-FLEX (3539) **Toll Free Fax 1-888-329-8711**

FLEXIBLE SPENDING ACCOUNTS

If one of these events occur and you want to change your DCFSA election or amount you must see your Agency Benefits Coordinator to complete the Flexible Spending Account section of the Enrollment Worksheet on the date the change in family status occurs or within 60 days of the qualifying event. This rule applies even if you are on leave without pay or have terminated employment. A change in family status will require documentation (for example: marriage license, birth certificate) to verify the event. Send the form to the Employee Benefits Division at the address on the back of this book.

Terminated employee: If you terminate employment and if you have a positive DCFSA balance, you may continue to submit claims for eligible expenses incurred during the period of active status employment.

If a Day Care account is for you:

* See your Agency Benefits Coordinator and enroll.
* Keep this booklet for future reference.

VOLUNTARY LONG TERM CARE INSURANCE PLAN

General Description of Coverage

Long Term Care is the type of care received either at home or in a facility, when someone needs assistance with activities of daily living or suffers severe cognitive impairment. However, this is not medical insurance.

Eligibility: The Long Term Care Insurance plan (LTC) is offered through Unum Life Insurance Company of America. Coverage is available to all active employees and State retirees and their family members, including spouses, adult children, siblings, parents (in-laws included) and grandparents (in-laws included). Active employees and their spouses will have premiums payroll-deducted eligible State Retirees and all other family members will be direct billed for the coverage by UNUM to their home.

Medical Underwriting: Employees are medically underwritten with the exception of newly hired employees who enroll during their initial 60-day eligibility period. Medical underwriting is also required for enrollment in the Long Term Care Plan for retirees and family members of active employees and retirees. This means you must complete a UNUM Long Term Care Medical Questionnaire. UNUM will evaluate the Medical Questionnaire to determine if the person meets their criteria to be enrolled in the LTC plan.

The Plan Choices

Facility Benefit Duration	3 Years or 6 Years			
Facility Monthly Benefit Amount	$2,500 or $3,000 or $4,500 or $6,000*			
Plans	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
Long Term Care Facility	100%	100%	100%	100%
Assisted Living Facility	100%	100%	100%	100%
Professional Home Care	50%	50%	50%	50%
Nonforfeiture	N/A	Yes	N/A	Yes
Compound Inflation	N/A	N/A	Yes	Yes

A UNUM Long Term Care Medical Questionnaire must be completed for all active employees and all family members, except for newly hired active employees who enroll during their initial 60 day eligibility period. The plan choices in the chart above allow you to choose the plan options that best meet your needs. Please mail the completed Long Term Care Application directly to UNUM.

When Benefits Begin - you are eligible for a monthly benefit after:

- You become disabled as defined by the plan;
- You are receiving services in a Long Term Care Facility or Assisted Living Facility, or receiving professional Home Care Services;
- You have satisfied the 90-day Elimination Period; and
- A physician has certified that you are unable to perform, without substantial assistance from another individual, two or more Activities of Daily Living (ADL) for a period of at least 90 days, or that you suffer severe cognitive impairment. You will be required to submit a physician certification every 12 months.

LONG TERM CARE

ADL losses and cognitive impairment must occur after the effective date of coverage to qualify for benefits.

Activities of Daily Living (ADLs) are:

- Bathing - washing oneself by sponge bath; or in either a tub or shower, including the task of getting in or out of the tub or shower with or without equipment or adaptive devices.
- Dressing - putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring - moving into and out of a bed, chair or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Eating - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Severe Cognitive Impairment - a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in:
  - Short or long term memory;
  - Orientation to people, places or time; and
  - Deductive or abstract reasoning.

Other Definitions:

- **Benefit Duration** - the 3 year or 6 year length of time you purchase to receive benefits at the long term care facility or nursing home facility level.
- **Assisted Living Facility** - an assisted living facility that is licensed by the appropriate agency (if required) to provide ongoing care and services to a minimum of 10 inpatients in one location.
- **Professional Home Care** - includes visits to your home by a Home Health Care Provider during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy, or homemaker service is provided.
- **Respite Care** - formal care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities. If you are eligible for a home care monthly benefit but benefits have not yet become payable, payments will be made to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your home care monthly benefit for each day that you receive respite care.
- **Optional Inflation Protection (compound capped)** - your monthly benefit will increase each year on the Policy Anniversary by 5% of the original Monthly Benefit. Increases will be automatic and will occur regardless of your health and whether or not you are disabled. Your premium will not increase due to automatic increases in your Monthly Benefit.
- **Nonforfeiture Benefit (Shortened Benefit Period):** If your coverage lapses due to nonpayment of premium after your coverage has been in force for three years, you will be eligible for a Nonforfeiture Benefit. This means your coverage will continue in force with the same level of benefits, except for a reduction in your Lifetime Maximum Amount.

Questions?

If you have questions about the Long Term Care Insurance coverage, please call Unum's LTC toll-free service number at 1-800-227-4165. This number will be available through the enrollment period, Monday - Friday, 8 a.m. - 8 p.m., EST. If you are interested in enrolling in the LTC plan, Unum representatives will mail you an Enrollment Kit with further information on the Plan Choices and the cost of each Plan Choice. The enrollment kit will also include an Application Form and Medical Questionnaire. All enrollment information is maintained by Unum.

OVERVIEW OF ADMINISTRATIVE POLICIES

The State of Maryland offers a wide range of health benefits to State employees and retirees. In order to offer such a variety of plans as well as certain pre-tax benefits, the State must comply with certain Federal and State laws and policies. The following sections give a general overview of applicable State policies and procedures that govern the State Health Benefits Program. Please refer to these sections to find the information you need to make an informed decision about health care coverage as well as how to use your coverage throughout the year. We have also included a glossary and index to further assist you in finding health benefits information in this book.

If you have any other questions concerning the State's policies, please contact your Agency Benefits Coordinator or the Employee Benefits Division.

ELIGIBILITY FOR BENEFITS

Eligible Employees

- Employees who are regularly paid salary or wages through an official State payroll center, including but not limited to: Central Payroll Bureau, Mass Transit Administration, and University of Maryland, including graduate assistants, and the University's Far East and European Divisions.
- Elected State Officials
- Registers of Wills and employees of the office of Registers of Wills
- Clerks of the Court and employees of the offices of Clerks of the Court
- State Board or Commission members who are regularly paid salary or wages and work at least 50% of the work week
- Employees of political subdivisions which participate in the State's health benefits program with the approval of the governing body
- Employees of agencies, commissions, or organizations permitted to participate in the State's health benefits program by law

Note: An active State employee must work at least 50% of the normal work week to receive the full State subsidy for health benefits for the employee and eligible dependents.

Note: An eligible employee must enroll within 60 days of the date of hire, or otherwise wait for the next Open Enrollment period.

Eligible Dependents

- A spouse (a husband or wife who is joined in marriage to an employee by a ceremony recognized by the laws of the State of Maryland)
- A never-married child of an employee until the end of the calendar year in which the child becomes 19. An unmarried child means:
    - A blood descendent of the first degree, (i.e., son or daughter),
    - A legally adopted child,
    - A step-child permanently residing with the employee, and supported 50% or more by the employee,
    - A child permanently residing in the employee's household, supported 50% or more by the employee, if the child is directly descended from or placed in the legal guardianship of the employee.

• A never-married child 19 years or older who is incapable of self-support because of mental or physical incapacity given that:
  • the condition leading to the incapacity began before the child's 19th birthday (or 25th if a full-time student),
  • the incapacity is permanent, and
  • the child resides permanently with the employee and is supported 50% or more by the employee.
• A never-married child who is attending an accredited educational institution full-time until the end of the calendar year in which the child turns 25 or the end of the month in which the child ceases to be a full-time student, whichever occurs first.

DUPLICATE COVERAGE:
A husband and wife who are both State employees may NOT have duplicate coverage under any plan by covering each other under separate enrollments. Also, children of a husband and wife who are both State Employees may NOT be covered twice under both parents' plans.

Coverage for Full-Time Students Beyond Age 19: Verification

Full-time students beyond the year in which they turn 19 can be continued in the benefits program. Coverage can be continued as long as they are full-time students, through the end of the month in which they cease to be a full time student or through the end of the year in which the full-time student turns age 25, whichever comes first. For example, a full-time student who graduates in May may continue through May 31. Ineligible children who are no longer full-time students can continue their coverage in the benefits program through COBRA. Please see the Continuation of Coverage/COBRA section of this booklet for more information.

It is the employee's responsibility to file an Enrollment Worksheet to add or delete dependents within 60 days of any qualifying event (loss of full-time status, age limitation, marriage, birth, divorce, death, etc.).

It is the responsibility of the employee to complete an Enrollment Worksheet to remove their child from their coverage when the child is no longer a full-time student. The Employee Benefits Division will process the Enrollment Worksheet to remove the child from the coverage for the next available pay period ending date.

NOTE: A full-time student must enroll and attend class for the number of credit hours per academic semester determined by the institution to be full-time status and complete the semester. It is the employee's responsibility to supply the health plan and/or the Employee Benefits Division with full-time student verification for each semester for each year. A dependent may be listed on the employee's dependent file. However, if the health plan and/or the Employee Benefits do not receive the full-time student verification within the timeframe allowed, claims will not be paid out and the dependent will be terminated.

NOTE: If the dependent is enrolled as a full-time student the next semester, you may add them back to your coverage by submitting an Enrollment Worksheet and full-time documentation within 60 days of the start of their semester.

Contact your Agency Benefits Coordinator or the Employee Benefits Division if you are uncertain about any qualifying event that will impact your health benefits. Only the Employee Benefits Division can modify your benefits.

Failure to delete ineligible dependents may result in disciplinary action, termination of employment, and/or criminal prosecution. IF YOU ATTEMPT TO ADD AN INELIGIBLE PERSON TO YOUR COVERAGE, OR IF YOU FAIL TO REMOVE A DEPENDENT WHO IS NO LONGER ELIGIBLE, YOU WILL ALSO BE REQUIRED TO PAY THE FULL INDIVIDUAL PREMIUM FOR THE INELIGIBLE PERSON.

Required Documentation for Dependents

Documentation is required from employees in order to enroll dependents. The following chart provides a listing of the documents needed to enroll a dependent. Photocopies are acceptable. Please see page 66 for a copy of the State Affidavit. Outside of Open Enrollment, a documented qualifying event must occur. Foreign Documents must be translated into English by an official translator other than the employee, available at any college or university.

For Spouse	For Unmarried Children	For Legal Ward or Court-Ordered Support
✔ State Official Marriage Certificate	For Natural Child: ✔ Natural Child's Official Birth Certificate (which must show the State Employee/Retiree's name as parent)	For Legal Ward: ✔ Copy of Court Appointed Guardianship Papers (Permanent Custody) signed by judge or other court officials ✔ State Affidavit
To remove a spouse from your plan outside of the Open Enrollment period: ✔ Limited Divorce, Legal Separation Decree (must be signed by a Judge or other Court Official) ✔ Divorce Decree (must be signed by a Judge)	For Adopted Child: ✔ After adoption: copy of final adoption decree signed by a judge or a State issued Birth Certificate (showing the State employee as the parent) ✔ For Foreign adoptions, documentation of entry into United States (translated into English) in addition to documentation noted above ✔ Pending Adoption: Notice of placement for adoption provided on adoption agency letterhead or copy of court order placing child pending final adoption	For Medical Child Support Order: ✔ Copy of Court Order requiring employee to provide support and health coverage; must be signed by the child support officer or judge ✔ State official birth certificate (certificate must indicate State employee as parent)
	For Step-Child: **(must reside with State of MD employee)** ✔ Copy of Child's Official Birth Certificate and, ✔ Copy of Marriage Certificate, and, ✔ State Affidavit and, ✔ Applicable Divorce Decree or legal Custody Papers	
	For Disabled Child: ✔ Provide Physician Verification of permanent disability (Verification of the disability will be required every 3 years) ✔ Official Birth Certificate	
	For Grandchild or other Direct Dependent of Employee **(must live with and be supported by State empoyee)** ✔ Copy of child's and grandchild's official birth certification showing line of relationship. ✔ State Affidavit certifying residence and support	
	For Overage Dependents 19-25: ✔ Verification of Full-Time Student Status per semester/Disability Certification See form in this booklet. ✔ State Official Birth Certificate	

Qualified Medical Child Support Orders

The Omnibus Reconciliation Act of 1993 (OBRA93) requires employers to provide benefits to dependent children and adopted children of employees/retirees under court-ordered Qualified Medical Child Support Orders (QMCSO). The main purpose of the QMCSO is to assist divorced spouses of employees/retirees in obtaining health care for dependents and reimbursement for expenses incurred for these eligible dependents. Your natural and adoptive children are eligible to be included in your coverage, regardless of where they live. If you have not been covering an eligible dependent and are ordered to do so by a QMCSO, you must complete an Enrollment Worksheet and attach a copy of the QMCSO. A QMCSO is a qualifying change, allowing you to add a dependent without waiting for Open Enrollment. The State employee must provide a written statement to the Employee Benefits Division authorizing the custodial parent to receive membership cards, EOB's, reimbursements, etc.

Contractual and Part-Time Employees

Contractual and part-time State employees are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts and Long Term Care. Part-time employees who work less than 50% of a regular work week and contractual employees must pay the entire cost of the plans, including the State subsidy. If you are a part-time employee, you must enroll within 60 days of your employment start date or at Open Enrollment. If you are a contractual employee, you must enroll within 60 days of your **first** contract date or at Open Enrollment. Contractual and part-time employees must follow the same participation rules as full-time employees, with the exception of the following:

1) The effective date of coverage cannot be changed once the Enrollment Worksheet has been processed. (A letter must be attached with the Worksheet if the employee is requesting an effective date other than the current processing date.)
2) Changes to coverage can only be made if you have a qualifying event according to IRS regulations (see section on Changes in Coverage) or during Open Enrollment. (Not at the time of a contract renewal).
3) If you leave State service, you need to notify the Employee Benefits Division in writing to receive your COBRA package.

All contractual and part-time State employees will be mailed payment coupons, which must be included with their premium payments at the address given on your enrollment worksheet. Your benefits will be effective as of the date noted on your letter but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the 1st of every month with a 30 day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the month, benefits will be terminated and may not be re-instated until the next Open Enrollment Period. Payment deadlines are strictly enforced.

NOTE: If you do not receive these coupons within one month of signing your Enrollment Worksheet or you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

Coordination of Benefits (COB)

Coordination of benefits occurs when a person has health care coverage under more than one plan. Coordination of benefits restricts the total medical expense reimbursement from more than one plan to 100 percent of the allowable medical expenses, thereby avoiding duplicate payments. It also provides the sequence in which coverage will apply when a person is insured under two plans.

NOTE: All plans participating in the State Health Benefits Program require information from State employees or retirees on other coverage that they or their dependents may have from another health insurance carrier. Failure of the State employee or retiree to provide this information will result in their claims being rejected until the information is received. All plans enforce Coordination of Benefits rules when paying claims.

Questions?

If I am a State employee and want to cover my spouse on my coverage, and my spouse has medical plan coverage with another employer, how do we handle a claim for benefits?

Any claim for benefits must be submitted to the benefits plan that provides primary coverage. For example, if a State employee or retiree has a claim for benefits, the claim is submitted to the State plan first. If the spouse has coverage from a different employer, the spouse's claim is submitted to the spouse's employer's medical plan first. After the primary medical plan has determined what benefits will be paid, balances may be submitted to the other medical plan for review. That plan will then review the claims and make any additional payments, if necessary.

My spouse is covered under my State medical plan, but is also eligible for medical plan coverage with my spouse's employer. Must my spouse sign up for their employer's medical plan coverage?

No. You may choose to cover your spouse only under the State medical plan. If you and your spouse choose to be covered under only one plan, you must be aware that there are limitations to enrolling in the other plans at a later date. Your spouse should check with his or her employer to determine when your spouse will be eligible to enroll in that coverage, should your spouse choose to do so at a later date. Conversely, you may also choose to cover yourself and your spouse only on your spouse's medical plan. If you choose to cover your family solely under your spouse's medical plan, you will not be able to enroll in the State benefits program except during Open Enrollment unless your spouse loses his or her benefits coverage or if there is a significant change in the health coverage offered.

My spouse, who is employed by another employer, and I both cover our children under our respective medical plans. If one of our children receives medical care, under which medical plan do we file a claim?

The State benefits program follows the rules established by the National Association of Insurance Commissioners (NAIC) for Coordination of Benefits. According to the rules established by NAIC, the parents' birth dates determine the primary coverage of the children covered under both parents' plans when the parents are not divorced or separated. The responsibility for primary coverage falls to the parent having the earlier birthday in the calendar year.

NOTE: A husband and wife who are both State employees (or who are both State retirees, or who otherwise are both covered under the State Health Benefits Program), cannot have duplicate coverage under any plan by covering each other under separate enrollments. Children of a husband and wife who are both State employees or retirees cannot be covered twice under both parents' plans.

Other Questions?

If you have any other questions about eligibility, please contact your Agency Benefits Coordinator or the Employee Benefits Division at the phone number listed on the back cover of this booklet.

State of Maryland
Sworn Affidavit of Eligibility of Coverage
For Stepchildren, Grandchildren and Court-Ordered Dependents
For Participation in the State Health Benefits Program

Please complete one Affidavit for Each Dependent

Employee Name: _____
Last First M

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Name of Dependent: _____
Last First MI

Date of Birth: ☐☐-☐☐-☐☐

Dependents Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Relationship to Employee:
☐ Stepchild
☐ Grandchild (Must be a direct decendent of the Employee)
☐ Court-Ordered Dependent (Legal Ward)

I have attached the following additional documentation to this Sworn Affidavit:

☐ For Stepchild: (1) Copy of State Employee's Marriage Certificate
(2) Stepchild's Birth Certificate
(3) Applicable Divorce Decree or Custody Papers

☐ For Grandchild: (1) Copy of Grandchild's Birth Certificate
(2) Copy of Parent's Birth Certificate (who is the child of the State Employee)

☐ For Court-Ordered Dependent: Copy of court papers signed by a judge or other Court Official, indicating Permanent Custody

Certification Statement

I certify and swear that the dependent listed above who is not my biological or adopted child, is permanently living in my household 100% and is fully dependent upon me for 50% or more support. I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true to the best of my knowledge, information, and belief.

_____ _____
Signature of Employee Date

EFFECTIVE DATES OF COVERAGE FOR ACTIVE EMPLOYEES

Effective Dates Generally (1st or 16th of the month)

The following rules apply to determine when your coverage begins and terminates:

- **Open Enrollment** changes always have an effective date of January 1.

- **New Enrollments** have an effective date of either the 1st or the 16th of the month, depending upon the pay period for which a deduction is taken from your pay check. New employees must file an Enrollment Worksheet within 60 days of their date of hire. You **MUST** discuss the need for retroactive coverage with your Agency Benefits Coordinator when you turn in your Worksheet.

- **Changes of Coverage** have an effective date of either the 1st or the 16th of the month, depending upon the pay period when the deduction changes on your pay check. Employees have 60 days from the date of the qualifying event (i.e., birth, death, loss of full-time student status, divorce, etc.) to file an Enrollment Worksheet to make the change in their coverage. You **MUST** discuss the need for retroactive coverage with your Agency Benefits Coordinator. Ex-spouses and dependents must be taken off at the time of the qualifying event. **Only the Employee Benefits Division has authority to modify your health benefits. All notification of changes should be sent to the Employee Benefits Division. Terminations in coverage are only permitted during Open Enrollment or within 60 days of an applicable qualifying event.**

- **Coverage for Your Newborn.** Employees have 60 days from the date of birth to add a newborn to their coverage by filing an Enrollment Worksheet. This mandatory requirement is for all newborns, even if you already have Family coverage. If you do not add a newborn to your coverage within 60 days of the date of birth, then you must wait until the next Open Enrollment period to add your child.

  Employees must submit a birth certificate as documentation of the child's eligibility, attached to the Enrollment Worksheet. If the employee does not yet have the birth certificate, then documentation from the hospital of the child's birth must be supplied. This documentation may include a copy of the newborn bracelet, footprint documentation, hospital discharge papers, etc. This documentation from the hospital of the child's birth will be accepted as **temporary documentation of the child's eligibility. However, the employee will be required to submit the proper birth certificate within 60 days of the date of receipt of the temporary documentation.**

  The Enrollment Worksheet will be processed for the next available pay period ending date to begin coverage for your newborn. **In order to cover your newborn from the date of their birth, you MUST submit a Retroactive Adjustment Form to cover your newborn from the date of birth. This applies even if you already have family coverage. See your Agency Benefits Coordinator for assistance.**

NOTE: In all the above circumstances, the Employee Benefits Division must be notified in writing through an Enrollment Worksheet within 60 days of the qualifying event (i.e., birth, death, loss of full-time student status, divorce, etc.). The notification must include all necessary documentation. Employees must also file a Retroactive Adjustment within 60 days of the date of the qualifying event, to obtain coverage back to the date of this qualifying event. See your Agency Benefits Coordinator for proper forms and for assistance. Failure to delete ineligible dependents will result in your being responsible for the total premium cost for that ineligible dependent's coverage and may result in disciplinary action, termination of employment, and/or criminal prosecution.

EFFECTIVE DATES OF COVERAGE

- **Termination of Coverage.** When you terminate employment, your coverage continues in effect through the end of the time period covered by your last premium deduction. **When you terminate employment, you may be eligible to continue your coverage under COBRA. Please see the COBRA section of this book for more information.**

NOTE: It is your responsibility to verify your benefits deductions on your check stub to make sure they match the coverage you requested. It is your responsibility to check your Summary Statement to make sure the benefits match the coverage you requested. You must contact your Agency Benefits Coordinator immediately if there is an error or omission in your deductions, and must report the error or omission to the Employee Benefits Division within 60 days.

Retroactive Coverage

Your effective date of new coverage or a change in coverage depends upon when your payroll deductions start or change. Under certain circumstances, you may obtain coverage back to the date of the qualifying event through a **retroactive adjustment.** See your Agency Benefits Coordinator for assistance. **You cannot retroactively fund a Flexible Spending Account for a backdated period of time.**

NOTE: You have 60 days from the date of an incorrect or missing deduction, or a qualifying event (i.e., marriage, birth of a newborn, adoption, etc.) to file for a retroactive adjustment. Retroactive adjustments are always required (mandatory) for newborns even if you already have existing family coverage, but certain changes in coverage will not impact your payroll deductions (i.e. adding a newborn when you already pay the family coverage level deduction.) Discussion with your Agency Benefits Coordinator about retroactive adjustment coverage is very important.

Payroll Deductions and Effective Dates of Coverage

The effective dates of coverage depend upon the pay period ending date for which a deduction is taken from your paycheck. The pay period ending date is shown on the check stub of each paycheck. Paychecks are given to employees approximately one week after the pay period ending date shown on the chart.

Pay Period Ending Date for Central Payroll Employees	Pay Period Covered by Deduction Premium Payments	Pay Period Ending Date for Univ. of MD Employees	Pay Period Covered by Deduction Premium Payments
01/06/2004	01/01 -01/15/2004	01/10/2004	01/01 -01/15/2004
01/20/2004	01/16-01/31/2004	01/24/2004	01/16-01/31/2004
02/03/2004	02/01 -02/15/2004	02/07/2004	02/01 -02/15/2004
02/17/2004	02/16-02/29/2004	02/21/2004	02/16-02/29/2004
03/02/2004	03/01 -03/15/2004	03/06/2004	03/01 -03/15/2004
03/16/2004	03/16-03/31/2004	03/20/2004	03/16-03/31/2004
03/30/2004	No deductions taken		
04/13/2004	04/01 -04/15/2004	04/03/2004	04/01 -04/15/2004
04/27/2004	04/16-04/30/2004	04/17/2004	04/16-04/30/2004
05/11/2004	05/01 -05/15/2004	05/01/2004	05/01 -05/15/2004
05/25/2004	05/16-05/31/2004	05/15/2004	05/16-05/31/2004
06/08/2004	06/01 -06/15/2004	05/29/2004	No deductions taken
06/22/2004	06/16-06/30/2004	06/12/2004	06/01 -06/15/2004
		06/26/2004	06/16-06/30/2004
7/06/2004	07/01 -07/15/2004		
07/20/2004	07/16-07/31/2004	07/10/2004	07/01 -07/15/2004
08/03/2004	08/01 -08/15/2004	07/24/2004	07/16-07/31/2004
08/17/2004	08/16-08/31/2004	08/07/2004	08/01 -08/15/2004
08/31/2004	No deductions taken	08/21/2004	08/16-08/31/2004
09/14/2004	09/01 -09/15/2004		
09/28/2004	09/16-09/30/2004	09/04/2004	09/01 -09/15/2004
10/12/2004	10/01 - 10/15/2004	09/18/2004	09/16-09/30/2004
10/26/2004	10/16- 10/31/2004	10/02/2004	10/01 - 10/15/2004
11/09/2004	11/01 - 11/15/2004	10/16/2004	10/16- 10/31/2004
11/23/2004	11/16- 11/30/2004	10/30/2004	No deductions taken
12/07/2004	12/01 - 12/15/2004	11/13/2004	11/01 - 11/15/2004
12/21/2004	12/16- 12/31/2004	11/27/2004	11/16- 11/30/2004
		12/11/2004	12/01 - 12/15/2004
		12/25/2004	12/16- 12/31/2004

NOTE: If you are a 21 or 22-Pay Faculty Member, your premiums are deducted on a bi-weekly basis during the school year. Multiple deductions are taken for: medical, prescription, dental, PA&D, and term life premiums, and long term care from the last paycheck you receive for the school year. Multiple deductions are not taken for contributions to a Flexible Spending Account. For Year 2004, all 21 or 22-Pay Faculty Members MUST contact the Personnel Office of their respective institutions for a Year 2004 schedule of paychecks and multiple deductions. Multiple deduction schedules differ by institution. Please refer to the charts in the Flexible Spending Account section of this booklet for approximate deductions for 21 or 22-Pay Faculty Members. This IRS plan does not allow changes in deferral amounts if you select the wrong amount.

Questions?

If I miss deductions for one or two pay periods, but I do not use any benefits, must I pay the missed premiums?

Yes. If you miss deductions for two pay periods, you must pay all missed premiums including the State subsidy (if applicable) or your coverage will be cancelled for the remainder of the calendar year. Missing two pay periods or less is considered a Short Term Leave of Absence. Please review the policy in the Continuation of Coverage section in this book. The Employee Benefits Division will bill you for missed deductions and any premiums. The payment deadline is strictly enforced.

If I miss deductions because I transfer between two agencies, or my benefits are cut off in error, am I covered?

You must pay any missed premiums or your coverage will be cancelled. Contact your Agency Benefits Coordinator immediately so that your coordinator can calculate your share of the premium and submit a Retroactive Adjustment Form. You are required to pay your share of the premiums at the time the Retroactive Adjustment Form is submitted.

If I miss deductions because I am a new employee, am I covered?

Coverage is effective when your benefit deductions begin. If you need services prior to the effective date of your requested coverage, your requested coverage can be effective as of the date you started work through the retroactive adjustment process. Payment for Retroactive Adjustment coverage is required within 60 days of your hire date. See your Agency Benefits Coordinator.

If I take a Leave of Absence, may I continue my benefits?

Yes, under certain circumstances, you may be eligible for continuation of coverage. Please see the Continuation of Coverage section in this book and contact your Agency Benefits Coordinator.

If I leave State service or one of my dependents becomes ineligible to continue on my benefits, what benefits are available?

For a review of benefits that are available when you terminate your State employment, or one of your dependents becomes ineligible, please see the Continuation of Coverage section of this book and contact your Agency Benefits Coordinator.

My newborn's birth certificate has not been received and it's almost the end of the 60-day period. What do I do to enroll my newborn within the 60-day period?

You must submit the Enrollment Worksheet with documentation from the hospital of the child's birth. This documentation may include a copy of the newborn bracelet, footprint documentation, hospital discharge papers, etc. This documentation from the hospital of the child's birth will be accepted as temporary documentation of the child's eligibility. However, you will be required to submit the State-issued birth certificate to the Employee Benefits Division within 60 days of the Notice of Enrollment.

Other Questions?

Please contact your Agency Benefits Coordinator for more information.

CHANGES IN COVERAGE FOR ACTIVE EMPLOYEES

The State Health Benefits Program operates as a pre-tax cafeteria benefits program under Section 125 of the Internal Revenue Service (IRS) Code for employees. The IRS regulations governing the program do not permit changes after Open Enrollment, except in very limited circumstances. Once you have elected a plan, you must stay in the selected plan, at the selected coverage level, for the full plan year, unless there has been a qualifying event. The plan year runs from January 1 to December 31.

A qualifying event is a change in status, such as the birth of a child, loss of a dependent, marriage, or divorce. A qualifying event can also occur in cases where your spouse's employment is terminated. You have 60 days from the occurrence of the qualifying event to make changes to your benefits. The changes made, however, must be because of and consistent with the change in status that has occurred. An Enrollment Worksheet must be completed. See your Agency Benefits Coordinator.

NOTE: Mistakes in completing the Enrollment Worksheet, using the IVR and dependent enrollment system, and other errors made by the employee do not constitute administrative (State) errors under IRS regulations.

The penalty for non-compliance with the IRS regulations is the loss of tax-exempt status for both the State and the employees in the Program. Changes outside of the Open Enrollment period will be permitted only in accordance with the IRS regulations. For this reason, you are cautioned to be very careful in making your selections.

IMPORTANT INFORMATION ON DIVORCE

On the effective date of the divorce, the ex-spouse MUST be removed from benefits coverage. Ex-spouses cannot be continued on any of the benefit plans, except under COBRA coverage. It is the responsibility of the employee to complete an Enrollment Worksheet to remove an ex-spouse from their coverage as soon as they are divorced, but no later than 60 days from the date of the divorce. If you fail to remove your ex-spouse from your coverage within 60 days of your divorce, you will be required to pay the full insurance premium for your ex-spouse from the date of the divorce, and may face disciplinary action, termination of employment and/or criminal prosecution.

NOTE: If an employee is obligated through terms of the divorce to provide health insurance coverage for the ex-spouse, that coverage can be provided for a limited time under COBRA and Maryland law. The ex-spouse cannot be continued on the employee's State benefits coverage and cannot receive a State subsidy of premiums. After COBRA coverage expires, the ex-spouse cannot continue to participate. COBRA coverage is not subsidized by the State. Please see the Continuation of Coverage/COBRA section of this booklet for more information.

Questions?

Can my overage dependent that is not or is no longer a fulltime student be enrolled in Cobra?
Yes. If you elect COBRA coverage for your dependent, please be advised that the COBRA effective date will be backdated to the end of the year that your dependent turned 19, the end of the month in which they cease to be a fulltime student or the COBRA would be effective the beginning of the month that the non-verified Semester began. You will be paying 100% of the premiums plus a 2% administrative fee. The State does not pay any portion of the premium.

CHANGES IN COVERAGE

If I obtain a Limited Divorce or Legal Separation, can I remove my spouse from my coverage?
A spouse may be removed from your coverage if you obtain a Limited Divorce (in Maryland) or Legal Separation signed by a Judge. Once removed, however, your spouse cannot be re-enrolled until the next Open Enrollment period provided they are still eligible (not divorced). You must file an Enrollment Worksheet within 60 days of the date of the court-signed document to remove your spouse from your coverage.

What if I make a mistake in my coverage or change my mind?
Under Internal Revenue Service rules, we cannot correct mistakes made by the employees at the time of enrollment. Also, we cannot allow changes unless there is a qualifying change in status. Please be very careful when selecting your coverage.

My spouse's Open Enrollment period is different from the State's. Is this a qualifying event?
Your spouse's Open Enrollment **is** a qualifying event according to Internal Revenue Service regulation governing our program. However, what changes to benefits you wish to makes need to be consistent with the change in the spouse's benefits. You must provide documentation from your spouse's employer of the benefits available prior to the Open Enrollment and the benefits available after the Open Enrollment for consideration of a change.

Under what circumstances would a refund be denied?
A refund request for any reason other than an administrative error by a State agency cannot be approved. Examples of refund requests that will be denied include:

- An incorrect coverage level due to a dependent no longer being eligible for coverage or overage dependents who are not full-time students or disabled or failure to provide proof of full-time student status or disability as required;
- An incorrect coverage level due to the death/divorce of a spouse;
- An incorrect coverage level due to a change in Medicare status;
- Incorrect benefits due to an incorrectly completed Enrollment Worksheet or resulting from incorrect use of the IVR during the annual Open Enrollment period;
- Refunds will not be provided for multiple deductions; or
- Incorrect deductions for changes that were not made within 60 days of the qualifying event, or
- Retroactive Terminations.

If you believe you are owed a refund because of a State Agency error, you must submit a refund request in writing within 60 days of the date of the incorrect deduction. Once benefits are received after the date of ineligibility, no refunds are warranted. For all circumstances in which a coverage level must be changed, you must submit a completed Enrollment Worksheet to change the coverage level.

Can I change health plans if my physician, dentist or other provider is no longer affiliated with my current plan?
No. The State cannot guarantee the continued participation of a particular provider in any of the State plans. Providers have the ability to terminate their association with a plan or close their panel to new patients at any time. See your Agency Benefits Coordinator to make alternative selections from the appropriate plan directory of providers. If your health care provider discontinues participation in the plan, you will not be allowed to change your plan, except during Open Enrollment.

Who has the authority to modify my benefits once I have enrolled?
Only the Employee Benefits Division has the authority to modify your benefits.

Other Questions?

If you have any other questions about changes or errors in your coverage, please contact your Agency Benefits Coordinator.

CONTINUATION OF COVERAGE/LEAVE OF ABSENCE AND COBRA

If you take a leave of absence without pay (LAWP), or leave State service, or if one of your dependents becomes ineligible to continue coverage under the State Health Benefits Program, you or your dependent may be eligible to continue health benefits coverage under a variety of regulations. Please note that if you leave State service and return within the same calendar year, you can re-enroll in State benefits. If you return within 30 days of your termination date, you must enroll in the same benefits at the same coverage level when you experienced a qualifying change in status.

Leave of Absence Without Pay (LAWP)

If you take a leave of absence pursuant to the Family Medical Leave Act (FMLA), special rules govern the continuation of your health benefits. Contact your Agency Benefits Coordinator.

Short Term LAWP: If you are on a short term LAWP (two pay periods or less for employees who are paid bi-weekly), that is not FMLA leave, you must continue all benefits and you will be billed by the Employee Benefits Division for your missed premiums. The Employee Benefits Division will bill for missed deductions and the payment deadline is strictly enforced. **NOTE: If you fail to pay outstanding premiums within the requested time frame, your health benefits will be cancelled. You will then have to wait until the next Open Enrollment period to obtain coverage. Payment is required even if deductions resume. The State cannot double bill for deductions from your paycheck to make up for missed deductions and employees cannot have a lapse in deductions.**

If your short term LAWP is due to a job-related accident or injury, or an approved FMLA leave, you are entitled to a State subsidy and are responsible for the employee share of the premium only. Contact your Agency Benefits Coordinator and request your Coordinator to return the no-pay bill to the Employee Benefits Division along with a copy of the first report of accident or injury or FMLA approval, a retroactive adjustment form, and your check for your share of the premiums.

NOTE: Even if the LAWP is due to a job-related accident or injury or approved FMLA leave, you must make up missed premiums within the requested time frame or your health benefits will be cancelled. Payment deadlines are strictly enforced.

Long Term LAWP: If you are on a leave of absence without pay for more than two bi-weekly pay periods, your leave is considered a long-term LAWP. If you are on an approved long-term LAWP, you may elect to continue or discontinue health insurance for the duration of the LAWP, up to a maximum of 2 years. Payment deadlines are strictly enforced.

You must complete a COBRA/LAWP Enrollment Worksheet and submit it to your Agency Benefits Coordinator. This Worksheet should be completed as soon as you know you will miss two pay periods or more. The Worksheet will not be accepted any later than 60 days after the effective date of the LAWP.

You may continue any or all health benefits options, and you may reduce your coverage level when enrolling for LAWP benefits. Otherwise, you are subject to the same limitations in changing coverage as an active employee.

When enrolled in LAWP, the employee is responsible for 100% of the premium unless the LAWP is due to a job-related accident or injury or approved FMLA leave. An employee on long term LAWP due to a job-related accident or injury or FMLA leave is entitled to the State subsidy. In this case, the Agency Benefits Coordinator must have the Agency Fiscal Officer complete the applicable section of the COBRA/LAWP Enrollment Worksheet. You will be billed by the Employee Benefits Division for the appropriate amount due. Payment deadlines are strictly enforced.

CONTINUATION OF COVERAGE/ LEAVE OF ABSENCE/ COBRA

NOTE: If you fail to pay any outstanding premiums within the required time frame, your health benefits will be cancelled. You will have to wait until the next Open Enrollment period to obtain coverage.

COBRA (Continuation of Coverage)

The State Employee Health Benefits Plan is covered by the Public Health Service Act (PHSA) and the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) which are included in the PHSA. Under these provisions, you may elect to continue certain group health benefits for a time frame determined in accordance with the regulations. These benefits include: medical, prescription, vision, and dental.

NOTE: If you choose to continue your coverage under these provisions, you will be responsible for paying 100% of the premiums, plus an additional 2% of the premium to defray administrative costs. Payment deadlines are strictly enforced.

You may continue your current coverage if you meet the following conditions:

- You have a qualifying event as defined below, and
- You submit an Enrollment Worksheet for continuation of benefits to the Employee Benefits Division within 60 days of the qualifying event, and
- You pay the required premiums as billed by the due date shown on the bill.

QUALIFYING EVENT	PERSONS AFFECTED	LENGTH OF CONTINUATION OF COVERAGE
Termination of employee's employment (other than for gross misconduct)	Employee Spouse Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare,[1] whichever occurs first
Lay-off or resignation of employee	Employee Spouse Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare,[1] whichever occurs first
Reduction of employee's work hours (Less than 50% time)	Employee Spouse Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare,[1] whichever occurs first
Employee's or retiree's dependent child over 19 ceases to be a full-time student, turns 25; or at the beginning of the month in which the non-verified semester began, whichever occurs first.	Child	36 months or until eligible for coverage elsewhere, including Medicare,[1] whichever occurs first (COBRA effective date must be backdated for continuous coverage)
Birth of employee's child or legal adoption†	Dependent Child[2]	Dependent child may be added to existing COBRA coverage[2]

[1]If you are enrolled in Medicare Parts A&B prior to leaving State service, you are entitled to elect continued coverage at the full COBRA rate. If you become entitled to Medicare while on COBRA, you will not be able to continue your coverage after your entitlement date. If you have dependents on your coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.
[2]Please note that a qualified beneficiary who is already in COBRA may add a new spouse to COBRA coverage. However, the new spouse does not gain or have his/her own COBRA rights. The new spouse would only have COBRA coverage the same time period as the existing beneficiary.

NOTE: Your COBRA coverage ends as soon as you become eligible for Medicare. However, COBRA coverage for your spouse or dependents is not affected by your Medicare eligibility.

QUALIFYING EVENT	PERSONS AFFECTED	LENGTH OF CONTINUATION OF COVERAGE
Employee's or retiree's dependent child over 19 ceases to be a full-time student or turns 25, whichever occurs first	Child	36 months or until eligible for coverage elsewhere, including Medicare,[1] whichever occurs first
Death of State employee or retiree	Spouse Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare,[1] whichever occurs first
Election of Medicare as primary coverage by the State employee, and spouse or dependent children are not eligible for Medicare	Spouse Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare, whichever occurs first
Divorce or legal separation from employee or retiree	Legally-Separated Spouse Former Spouse Dependent Child(ren)	Indefinitely or until eligible for coverage elsewhere, including Medicare and remarriage
Total and Permanent Disability of employee (as defined by the Social Security Act) within the first 60 days of COBRA coverage	Employee Spouse Dependent Child(ren)	The 18 months of coverage can be extended to 29 months at increased premiums equal to 150% of usual premiums.[†]

***NOTE: If a surviving spouse of a State employee is the State employee's Retirement Beneficiary and will receive a monthly pension through the Maryland Retirement and Pension Systems under Retirement Options 2, 3, 5, or 6, and the deceased employee met certain age and service requirements, it is not necessary to apply for continuation of coverage under these provisions. The surviving spouse will have the option of electing coverage in the State Health Benefits Program as a retirement beneficiary. Call the Employee Benefits Division for more information.**

To enroll in COBRA, you must complete and sign a COBRA/LAWP Enrollment Worksheet and return it to the Employee Benefits Division within 60 days of the qualifying event. You then will be billed by the Employee Benefits Division for Continuation of Coverage premiums. These bills are in the form of pre-printed coupons for each month of coverage. The COBRA participant must certify that the participant is not covered, and is not eligible to be covered, under another group health plan.

If you do not elect COBRA during the required 60 day election time frame, or if the initial premium is not received within the required 45 day time frame, or if any required premium payment is not received within 30 days of the date due, you will be considered to have irrevocably waived all benefits available under COBRA regulations and your COBRA coverage will be terminated. COBRA benefits cannot be reinstated once terminated.

Conversion Privilege: When Active, LAWP, or COBRA eligibility ends, and you have exhausted the continuation of coverage options available as described above, you may be eligible to convert your coverage over to a non-group health insurance policy, billed directly through the health care plan. To qualify for the conversion privilege, you must request conversion of coverage through your health care provider within 60 days of the qualifying event. You or your eligible dependents will be billed directly at the applicable non-group rate by the health care provider.

Will a Flexible Spending Account affect my Social Security benefit?

Possibly - using tax-free dollars will lower your taxable pay. If your taxable pay is below the maximum Social Security wage base, this could produce a slight reduction in your ultimate Social Security benefit when you retire. However, the savings you realize from paying for benefits with tax-free dollars should more than offset any subsequent reductions in your Social Security benefit at retirement.

CONTINUATION OF COVERAGE/ LEAVE OF ABSENCE/ COBRA

NOTE: You must remove your ex-spouse and ineligible dependents from your coverage at the time of the divorce. Failure to do so may result in disciplinary action, termination of employment, and/or criminal prosecution. Your ex-spouse and and ineligible dependents are eligible for continuation coverage under COBRA. You will be charged the full individual premium for each month of coverage of an ineligible dependent and/or a former spouse.

HIPAA (Health Insurance Portability and Accountability Act)

Certificates of Coverage and the Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law, HIPAA, requires employers to provide certificates of coverage to all former employees, who then can give the certificates to their new employers. Some employer health plans have pre-existing condition exclusions, preventing immediate health insurance coverage for new employees. Certificates of coverage help reduce or eliminate the pre-existing condition exclusions under the new health plan. If you or your dependents obtain new employment, you may request a certificate of coverage from the State which describes the length and types of coverage (i.e., medical, dental, etc.) you and your dependents had under the State program. Please fill out and mail the following form (on page 77) to receive your certificates of coverage.

Notice of Privacy Practices and HIPAA Authorization Form

The State conforms to the federal HIPAA regulations and State regulations on the privacy of your health information. Please read the "Notice of Privacy Practices" which describes the privacy practices of the State Employees Health Benefits Program.

HIPAA and State regulations require your written authorization to disclose certain health information to plans and regulatory agencies. If your written authorization is needed, you may use the enclosed "HIPAA Authorization Form" to provide the needed authorization.

Questions?

If you have any questions about COBRA or Continuation of Coverage or HIPAA, please see your Agency Benefits Coordinator for more information.

Important Notice of Your Right to Documentation of Health Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs how health insurance plans handle pre-existing medical conditions when you are applying for health insurance coverage. Under the new law, your employer may require a Certificate of Health Coverage from your previous employer. If you or one of your dependents covered under the State Health Benefits Program is planning on changing jobs or already has done so, you may request a Certificate of Health Coverage that shows evidence of your prior health coverage with the State. If you buy health insurance other than through the State plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

You have a right to receive a certificate of prior health coverage as of July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate that documents your coverage under the State plan, complete the attached form and return it to:

Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, Maryland 21201
Attn: HIPAA Certificates

For additional information, call (410) 767-4775.

This certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage with the State.

Request for Certificate of Health Coverage

Name of Participant: _____ Date: _____

Social Security Number of Employee/Retiree: _____

Address: _____

_____

Daytime Telephone Number: _____

Name & Relationship of Any Dependents for Whom Certificates are Requested: _____

_____

Their Address(es) if Different From Above: _____

_____

NOTICE OF PRIVACY PRACTICES

STATE EMPLOYEES AND RETIREES HEALTH BENEFITS PROGRAM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under federal and State law, the Department of Budget and Management, Employee Benefits Division (EBD), which administers the State Employees and Retirees Health Benefits Program (the Program), protects the privacy of your protected health information. EBD takes steps to ensure that your protected health information is kept secure and confidential and is used only when necessary to administer the Program. EBD is required to give you this notice to tell you how EBD may use and give out ("disclose") your protected health information held by EBD. This information generally comes to EBD from you when you enroll in a health plan and from your health plan in the administration of the Program.

Your health plan in the Program (for example, the CareFirst Blue Cross Blue Shield PPO or the Optimum Choice HMO) will also use and disclose your personal health information. For questions about your health plan's policies and procedures and to exercise your rights regarding your protected health information held by your health plan, please contact your health plan directly.

EBD has the right to use and disclose your protected health information to administer the Program. For example, EBD will use and disclose your protected health information:

- To communicate with your Program health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue. EBD may need a written authorization from you for your health plan to discuss your case.
- To determine your eligibility for benefits and to administer your enrollment in your chosen health plan.
- For payment related purposes, such as to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to coordinate your benefits with other benefit plans (including workers' compensation plans or Medicare), or to make premium payments.
- For treatment related purposes, such as to review, make a decision about, or litigate any disputed or denied claims.
- For health care operations, such as to conduct audits of your health plan's quality and claims payments, or to procure health benefit plans offered through the Program.
- To investigate fraud in Program enrollment.
- To the health plan sponsor for effective administration of the health plan and the Program.

EBD will also use and give out your protected health information:

- To you or someone who has the legal right to act for you (your personal representative). To authorize someone other than you to discuss your protected health information with EBD, please contact EBD to complete an authorization form.
- To law enforcement officials when investigating and/or processing alleged or on-going civil or criminal actions.
- Where required by law, such as in response to a subpoena for records, to the Secretary of the federal Department of Health and Human Services or to the Office of Legislative Audits.
- When an authorization signed by you is presented to EBD for disclosure of the records.
- For healthcare oversight activities (such as fraud and abuse investigations).
- To avoid a serious and imminent threat to health or safety.

By law, EBD must have your written permission (an "authorization") to use or give out your protected health information for other purposes. You may take back your written permission at any time, except if EBD has already acted based on your permission.

By law, you have the right to:

- Make a written request and see or get a copy of your protected health information held by EBD.
- Amend any of your protected health information created by EBD if you believe that it is wrong or if information is missing, and EBD agrees. If EBD disagrees, you may have a statement of your disagreement added to your protected health information.
- Ask EBD in writing for a listing of those getting your protected health information from EBD for up to 6 years prior to your request. The listing will not cover your protected health information that was used or disclosed for treatment, health care operations or payment purposes, given to you or your personal representative, disclosed pursuant to an authorization, or was disclosed prior to April 14, 2003.
- Ask EBD in writing to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address) if using your address on file creates a danger to you.
- Ask EBD in writing to limit how your protected health information is used or given out. However, EBD may not be able to agree to your request if the information is used for treatment, payment or to conduct operations in the manner described above or if a disclosure is required by law.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at the EBD website: www.opsb.state.md.us/empbenefits/benefits.htm. You may also call 410-767-4775 and ask for EBD's Program privacy official for this purpose. If you believe EBD has violated your privacy rights set out in this notice, you may file a written complaint with EBD at the following address:

Employee Benefits Division
Room 510, 301 West Preston Street
Baltimore, MD 21201
ATTN: HIPAA Privacy Officer

Filing a complaint will not affect your benefits under the Program. You also may file a complaint with the Secretary of the federal Department of Health and Human Services at:

Department of Health and Human Services Office of Civil Rights
150 South Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111

EBD has the right to change the way your protected health information is used and given out. If EBD makes any changes, you will get a new notice. The privacy practices listed in this notice will be effective April 14, 2003.

State Employees & Retirees Health Benefits Program
Authorization Form for Release of Records and Information

COMPLETE SECTION A:

A. Identification

This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee/Retiree Name:

_____

Address: _____

_____

Employee/Retiree Date of Birth: _____

Daytime Phone Number: (_____) _____

Employee/Retiree Social Security Number: _____

Name(s) of Member(s), If other than Employee/Retiree (your Spouse and/or Dependent Children), about whom information may be used and/or disclosed:

_____

_____

B. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the member(s) listed in Section A to the individual or company identified in Section B.1a. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information, claims records, claims status, and patient management records, according to my directions.

CHECK ALL THAT APPLY IN SECTIONS B.1a AND B.1b:

B.1a. I authorize the disclosure of information to:

___ Benefits Review Committee
___ Employee Benefits Division
___ My Medical Plan (Name): _____
___ My Dental Plan (Name): _____
___ My Prescription Plan (Name): _____
___ My Physician/Provider (Name): _____
___ My Legal/Personal Representative (Name or describe): _____

_____

___ Other (Name or describe): _____

You Must Continue on the Next Page

B.1b. I authorize the obtaining of information from:

___ Benefits Review Committee
___ Employee Benefits Division
___ My Medical Plan (Name): _____
___ My Dental Plan (Name): _____
___ My Prescription Plan (Name): _____
___ My Physician/Provider (Name): _____
___ My Legal/Personal Representative (Name or describe): _____
_____
___ Other (Name or describe): _____

CHECK ALL THAT APPLY IN SECTION B. 2:

B.2. I authorize the disclosure and/or use of the following information:
_____ (a) any information related to a specific claim (specify date of service or type of treatment):
_____
_____ (b) my entire medical record
_____ (c) my enrollment, eligibility and premium payment records
_____ (d) Other (describe information in detail): _____
_____

CHECK ALL THAT APPLY IN SECTION B.3:

B.3. I authorize the disclosure and/or use for the following reason(s):
_____ (a) for review and appeal of a claim denial
_____ (b) for assistance with my plan coverages and benefits
_____ (c) for assistance with my dependent's plan coverages and benefits
_____ (d) for my own purposes
_____ (e) Other(describe purposes in detail): _____
_____

READ SECTION C:

C. Right to Revoke:
I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: Employee Benefits Division, HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, MD 21201, or via fax to 410-333-7104.

You Must Continue on the Next Page

YOU AND A WITNESS MUST SIGN IN SECTION D:

D. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I, _____ , have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____
Your Signature Date

_____ _____
Signature of Witness Date

(Witness cannot be the same person to whom Authorization is being given.)

COMPLETE SECTION E FOR A LEGAL/PERSONAL REPRESENTATIVE:

E. Legal Representative: If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name (PRINTED): _____

Legal Representative's Signature: _____

Date: _____ Daytime Phone Number: _____

1. If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the member.
2. Please provide a copy of this form to your authorized representative so that they will be able to establish the validity of their request for your protected health information.

Complete, Sign and Return this form to: Employee Benefits Division, HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, MD 21201 or Fax to: 410-333-7104.

RETIREMENT INFORMATION/MEDICARE

If you are thinking about retiring soon, you should be aware that there will be several changes in your health benefits. The major changes involves:

- Eligibility for State subsidy of your health benefits,
- Medicare eligibility,
- Term Life,
- PA&D plan, and
- Flexible Spending Accounts.

Eligibility for State subsidy of your health benefits: You may be eligible for State-subsidized health benefits when you retire from State service if you meet one of the following criteria:

- You leave State service with at least 16 years of creditable service with the State;
- You retire directly from State service with a State retirement allowance and with at least 5 years of creditable service with the State;
- You leave State service (deferring your retirement allowance) with at least 10 years of State creditable service and within 5 years of State normal retirement age, or
- You retire directly from State service with a disability retirement allowance.

A State employee who retires with 16 or more years of creditable service or who receives a disability benefit, regardless of years of service, receives the full State subsidy provided to an active employee. A State retiree otherwise eligible for health benefits with at least five years of creditable service, but less than 16 years, receives a pro-rated subsidy. Therefore, if you have between five and 16 years of service, you will pay a pro-rated share of the State subsidy in addition to the regular premium. The retiree must pay the difference between the pro-rated subsidy and the entire premium cost.

Medicare Eligibility: Medicare is a federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. As an active employee, you do not have to sign up for Medicare when you become eligible, and instead, may keep using the State health benefits as your only coverage. **However, when you retire, you and your spouse MUST sign up for both Medicare Parts A & B as soon as they are eligible due to age or disability.** Medicare then becomes the primary coverage and State coverage must be supplemental to Medicare. Persons who are certified by the Maryland State Retirement Systems as disabled and eligible for a disability retirement must apply for Medicare Parts A & B within 2 years (24 months) of the disability retirement date. If Social Security denies Medicare coverage, you must provide the Social Security documentation to the State.

End Stage Renal Disease (ESRD): If you are certified by Medicare as eligible for ESRD coverage, you must sign up for both Medicare Parts A and B as soon as you are eligible.

NOTE: When you retire, if you or your spouse is eligible for Medicare due to age or disability, and fail to sign up for Parts A& B, the person will be responsible for the portion of claims costs that would have been paid by Medicare. Claim costs that would have been paid by Medicare are not covered by the State health plan.

Term Life Insurance: Active employees who were enrolled in the State Term Life Plan on or after January 1, 1995 will be allowed to continue their enrollment with the applicable State plan. Please see the Term Life Insurance section of this book for more information.

Personal Accidental Death and Dismemberment Insurance (PA&D): This plan is not available to State retirees.

Flexible Spending Accounts: Flexible Spending Accounts are not available to State retirees.

Beneficiaries of Deceased Retirees

If you choose **Retirement Option 2, 3, 5, or 6,** and you met the age and service requirements to be eligible for coverage, your spouse will continue to have a monthly pension check at the time of your death and will be able to continue subsidized health benefits. The surviving spouse must be the sole primary retirement beneficiary to continue coverage. If you choose **Retirement Option 1, 4, or 7** your spouse will only be eligible for non-subsidized benefits under COBRA for a limited period of time.

Eligibility of Optional Retirement Program (ORP) Retirees

There are special rules effective October 1, 2001, governing the eligibility and costs of health benefits for Optional Retirement Program (ORP) Retirees (including Teachers Insurance and Annuity Association - College Retirement Equities Fund (TIAA-CREF), Valic, Aetna, and American Century):

- ORP retirees are eligible to participate in the State Employees Benefits Program, if:
  1. they retired directly from and had at least 5 years of State service with a Maryland State institution of higher education; or
  2. they ended State service with a Maryland State institution of higher education with at least 10 years of service and were at least age 57; or
  3. ended service with a Maryland State institution of higher education with at least 16 years of service.
- The full State subsidy for Individual coverage is available to ORP retirees who have 16 or more years of State service.
- ORP retirees with less than 16 full years of State service upon retirement receive a prorated State subsidy for their Individual coverage.
- The spouse or dependent children of the retired ORP employee may continue to be covered under the retired employee's coverage, upon payment by the eligible retiree of the entire difference in premium costs for the higher level of coverage, for ORP retirees with less than 25 years of State service.
- ORP retirees with 25 or more years of State service receive the full State subsidy for health benefits for their eligible dependents.
- The retiree's Agency Benefits Coordinator must forward the Benefits Enrollment Worksheet and attach a letter certifying the total number of years and months of service with the Maryland State institution of higher education, and when the employee is retiring or leaving State service.
- ORP retirees who are not eligible to participate in the State Retirees Benefits Program may continue their benefits under COBRA for up to 18 months.
- Upon the death of an ORP retiree with 25 or more years of State service, the eligible dependents may continue with the same State subsidy. Upon the death of an ORP retiree with less than 25 years of State service, the eligible dependents may continue with no subsidy but only if the eligible dependents receive a periodic distribution under an Optional Retirement Plan.

Questions?

If you have any questions about changes in coverage when you retire, please see your Agency Benefits Coordinator or contact the Employees Benefits Division at the phone number listed on the back cover of this book.

END STAGE RENAL DISEASE

If you are certified by Medicare as eligible for ESRD coverage, regardless whether you are an active employee or not, you must sign up for both Medicare Parts A and B as soon as you are eligible. Medicare is a federal health insurance program for people age 65 or older, certain people with disabilities who are under 65, and people of any age who have permanent kidney failure (ESRD). Medicare is administered by the Social Security Administration. Individuals who have permanent kidney failure (ESRD), regardless of their age, can receive services through Medicare.

Your State Employees Health Plan will be your primary plan for the first 30 months of the ESRD. At the end of the 30 month period, Medicare becomes the primary payer. It is crucial that you apply for Medicare Parts A and B. If you do not sign up for both parts of Medicare, Hospital Insurance (Part A) and Medical Insurance (Part B), you will be responsible for paying all charges that Medicare would have covered.

When you are eligible for Medicare, please contact your local Social Security Office and request a Medicare Handbook. This handbook will provide you with information on Medicare Coverage for Kidney Dialysis and Kidney Transplant Services.

When you are no longer eligible for Medicare Part A and Part B for ESRD, please contact your local Social Security Office and request a cancellation of your Medicare coverage. After you receive your cancellation letter, please complete an Enrollment Worksheet to change your coverage level and forward it to the Employee Benefits Division.

MARYLAND RELAY

Maryland Relay gives people who are deaf or hard-of-hearing the ability to communicate over the telephone with people who don't have such disabilities.

This service is available 24 hours a day, 7 days a week, with no restrictions on the length and number of calls placed by users. It can be reached from any phone or modem. There are no additional charges for local calls, and long distance calls are billed at reduced rates. Incoming or outgoing international calls are also available.

Call the Maryland Relay to connect with a Communications Assistant (CA). The CA will make the connection between the hearing person on the voice phone and the person with a hearing or speech disability on a text telephone (TT), also known as a TDD. The CA will type the conversation on the text telephone to one person and talk to the other person on the voice telephone.

HEALTH CARE FRAUD ■

HEALTH CARE FRAUD

Each year, health care fraud drains millions of dollars from employer-sponsored health plans, inevitably causing higher costs for all of us. As an employee or retiree enrolled in the State Health Benefits Program, you assume certain responsibilities:

- You are responsible for the accuracy of your benefits, including coverage levels, dependents, and payroll or retirement check deductions.
- You are responsible for the accuracy of your claim forms. If someone else files a claim on your behalf, you should review the form before signing it.
- You should never allow another person to seek medical treatment under your identity. If your plan card is lost, report the loss to the plan immediately. Plan phone numbers are located on the back cover of this book.
- You are required to assist the State in dealing with provider fraud by notifying the plan if a provider:
  - bills you or your health plan for services or treatments that you have never received,
  - asks you to sign a blank claim form, or
  - asks you to undergo tests that you feel are not needed.

NOTE: Health Care Fraud is a crime that can be prosecuted. Enrollment in or receipt of benefits to which you and/or your dependents are not entitled is considered fraud. If you willfully and knowingly engage in any activity intended to defraud the State Health Benefits Program, your benefits may be cancelled, you may be required to repay any claims or premiums that have been inappropriately paid, you may face charges for dismissal from State service, and you may face prosecution. If you attempt to add an ineligible dependent to your coverage, or if you fail to remove a dependent who is no longer eligible, you will be required to pay the full Individual premium for the ineligible person.

BENEFITS APPEAL PROCESS ■

BENEFITS APPEAL PROCESS

The Employee Benefits Division strives to ensure proper coverage and claims payments under the benefits program. If you believe that your plan has denied payment of a covered benefit to which you are entitled, you should contact the plan first. The plan will explain its appeal process and inform you of the steps you should take to file an appeal to the plan. HMO members may also file an appeal to the Maryland Insurance Administration (MIA) for HMO members.

Once you have exhausted all of the plan's appeals processes and if you are not satisfied with the plan's decision following its review of your appeal, you may submit a written request for review by the State Benefits Review Committee of the Employee Benefits Division. The State Benefits Review Committee reviews appeals by members and providers on denied benefits and/or disputed claims payments. This request must be submitted within 30 days of your receipt of the plan's decision, and should describe the nature of your claim and the reasons why you believe that the claim has been improperly denied. The Benefits Review Committee should render a decision on your claim within 90 days of receipt. The decision of the Benefits Review Committee will be final. The address of the Benefits Review Committee is: Benefits Review Committee, c/o Employee Benefits Division, 301 West Preston Street, Room 510, Baltimore, Maryland 21201, or fax to FAX# 410-333-7122.

Change of Name/Address Form-Active Employees

TO: Department of Budget and Management
Employee Benefits Division
301 W. Preston Street, Room 510
Baltimore, Maryland 21201

FROM: _____ (Employee Name)

RE: Change of Name and/or Address for Benefit Plans

Active Employee: _____ Contractual Employee: _____ Satellite Employee: _____

Please advise my benefit plans of my new name and/or address as follows:

EMPLOYEE SOCIAL SECURITY NUMBER: ☐☐☐-☐☐-☐☐☐☐

EMPLOYEE NAME:

Old Name: _____
Last First M

I
New Name: _____
Last First MI

NEW ADDRESS: _____
Street

_____
City or Town State Zip

NEW HOME PHONE: _____
Area Code Number

This form should be sent to the following benefit plans in which I am enrolled:

_____ Name of Health Plan: _____
_____ PCS Prescription Plan
_____ United Concordia
_____ Dental Benefit Providers
_____ Term Life Insurance Plan
_____ PA&D (Personal Accident and Dismemberment) Plan
_____ Health/Day Care Spending Accounts

_____
Employee Signature

_____
Date

_____
Agency Benefit Coordinator Signature

_____
Date

_____
Agency & Phone Number

NOTE: Payroll Change-of-Address Card **MUST** be sent to Central Payroll Bureau at the same time.

State of Maryland
Employee/Retiree Benefits Program Certification of Full-time Student Eligibility

Dependent children are covered through end of year in which they turn 19. Beyond that year, full-time student certification is required for dependents 20 to 25. The Standard Life covers full-time student dependents through age 25.

Employee to complete the following:

Employee/Retiree Name:	Employee/Retiree Social Security Number:
Dependent's Name:	Dependents Date of Birth: Month _____ Day _____ Year _____
Dependent's Sex: ☐ Male ☐ Female	Relationship to Employee:
Dependent's Social Security Number:	Dependents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Do you provide 50% of the dependent's support? ☐ Yes ☐ No

Does the dependent reside with you? ☐ Yes ☐ No

I hereby certify that the information contained on this form is correct to the best of my knowledge and authorize the release of any information requested with respect to this certification.

_____	_____	_____
Employee/Retiree Signature	Daytime Telephone Number	Date

Student Certification: School Official to complete this section if dependent is eligible based on student status:

School Name:	School Address:

Beginning and Ending Date of Current Semester: _____ to _____

Which Semester does this certification apply? Fall _____ or Spring _____

Is this institution accredited? ☐ Yes ☐ No

Credit Hours per Current Semester or Classroom Hours per Week: _____

What is the student status as determined by the institution: ☐ Full-time ☐ Part-time

SUMMER SESSIONS

Is Student currently enrolled for a summer session? ☐ Yes ☐ No

If yes, did student attend spring semester preceding break? ☐ Yes ☐ No

Is student enrolled for the fall semester? ☐ Yes ☐ No

I hereby certify that the above information is correct to the best of my knowledge.

_____	_____	_____
Signature of School Official	Daytime Telephone Number	Date

Please note: The State member may complete the top portion of this form and attach a letter from the College Registrar's office. Please be advised that the letter from the College Registrar's office must be on official school stationary and be signed by the School's Administrative office or Registrar's office. The information must state the dependent's name, and indicates that the dependent is a full-time student for the **Current** semester. You may also attach documentation of payment on official school stationary showing the **PAID** Full-time tuition that states the dependent's name and states that this dependent is a full-time student for the **Current** semester.

We will not accept a copy of an unpaid tuition bill as verification of full-time student status.

State of Maryland
State Employee Health Benefits Program
Certification of Disabled Dependent

This portion to be completed by Employee/ Retiree.

Employee/Retiree Name:	Employee/Retiree Social Security Number:
Dependent's Name:	Dependents Date of Birth: Month _____ Day _____ Year _____
Dependent's Sex: ☐ Male ☐ Female	Relationship to Employee:
Dependent's Social Security Number:	Dependents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Does this dependent reside with you? ☐ Yes ☐ No

Do you provide 50% or more of the dependent's support? ☐ Yes ☐ No

Is this dependent a current SSI recipient due to disability? ☐ Yes ☐ No

(Please enclose letter of determination from SSI)

Does this dependent have Medicare A or Part B? ☐ Yes ☐ No

Effective date: _____

(Please enclose Medicare letter)

This portion to be completed by Physician.

This portion outlines documentation to be submitted by the dependent's personal physician. Information must be current (i.e. the patient has been examined within the last 6 months for medical or 3 months for mental health.

Diagnosis _____ Date of onset of condition_____

Prognosis _____

Does this condition impose on the individual's ability to perform daily duties, maintain gainful employment or maintain student status? ☐ Yes ☐ No

Is the dependent in an institution? ☐ Yes ☐ No

Institution name: _____

Name of Physician (please print) _____ Phone Number _____

Physician's Address _____

_____

Signature of Physician _____ Date _____

For medical disability request, please attach the most recent history and physical, which document the diagnosis and the functional limitations.

For mental health disability request, please attach the most recent psychiatric evaluation which documents the diagnosis and the functional limitations

All Protected Health Information provided by your dependent's physician will be kept confidential in accordance with the HIPAA law and will only be reviewed for the purpose of determining your dependent's disability.

Once this form and medical notes are returned along with the signed authorization form, we will forward all documentation to the medical plan for a determination. Please allow 30 days.

GLOSSARY

Allowed Amount: The maximum fee a health plan will pay for a covered service or treatment. The allowed amount is determined independently by each health plan.

Cafeteria Plans: Plans allowing employees to choose from a menu of one or more qualified benefits. Under Section 125 of the Internal Revenue Service Code, benefits from a cafeteria plan are not taxed to the employee who selects them.

CMS: Center for Medicaid and Medicare Services, the agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

COB: Coordination of benefits. If an employee, retiree, or covered dependent is covered under more than one insurance plan, the insurance companies determine which coverage is primary. The plan with primary coverage will pay its benefits first, without regard to other coverage.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985. This law amended by ERISA, the PHSA, and the tax code to require employers to offer the option of purchasing continuation coverage to qualified beneficiaries who would otherwise lose group health insurance coverage as the result of a qualifying event. The federal statute which applies to the State of Maryland Health Benefits Program is the Public Health Service Act (PHSA).

Coinsurance: The portion of medical services that the employee must pay in addition to the deductible.

Copayment: The amount of money an employee, retiree, or covered dependent pays at the time service is rendered. This money goes directly to the health care provider. The amount of the copayment varies by type of provider or plan.

Coverage, Limitations, Exclusions, or Preauthorization Requirements: The amount or extent to which any particular treatment or service is covered by a health plan.

Deductible: The amount of money an employee or retiree is required to pay before direct payment or reimbursement is available from the plan.

Dental Plan: A health plan that partially or fully reimburses employees and retirees for dental services.

Dental POS: A dental plan similar to a medical POS, allowing members to self-refer out-of-network for most services subject to higher fees. Braces must be in-network only.

DHMO: Dental Health Maintenance Organization. A plan similar to a medical HMO, but provides dental services. Participants can use only those designated dental providers approved by and registered with the DHMO.

ERISA: Employee Retirement Income Security Act of 1974. ERISA is the basic law designed to protect the rights of beneficiaries of employee benefit plans offered by private employers. The State Employees and Retirees Health Benefits Plan is not covered by ERISA.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses they incur. Money is deducted from pay checks on a pre-tax basis. It most often covers reimbursements for medical expenses not covered under other insurance, or day care expenses for eligible children and adults.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions by next employer.

HMO: Health Maintenance Organization. A network of medical providers that offers medical care to participants. Participants receive all medical care through their HMO.

In-Network Service: Service provided by a participating provider, Primary Care Physician, or provider approved by the plan.

IPA: Independent Practice Association. A type of HMO consisting of coordinated groups of physicians practicing out of individual offices.

LAWP: Leave of Absence Without Pay. An employer approved period of leave during which the employee is not paid, but does not terminate State service. Any approved leave of absence of two pay periods or less is considered a short term LAWP. Any approved leave of absence more than two pay periods is considered a long term LAWP.

Medical Necessity: All health plans require that a service or treatment must be considered a medical necessity to be covered. The definition of medical necessity varies by plan. Please contact your plan to determine what types of treatment and service are considered medical necessities.

Medical Plan: A health plan that partially or fully reimburses employees or retirees for costs of personal injuries or illness.

Medicare: A federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. Eligible Medicare participants must enroll in both Parts A and B, because the State plan is often the secondary payer, and will not cover expenses and claims covered by Medicare.

Network: A group of providers that have contracted with an insurance agency to provide services and treatment to individuals.

Open Enrollment Period: An annual period during which employees and retirees are given the option of enrolling in or changing one or more health care plans.

Out-of-Network Service: Service received from providers outside of the plan s network. Such services are subject to up-front deductibles and co-insurance, if they are even covered by the plan.

Plan: A health care program offered by the State that partially pays or reimburses the employee or retiree for covered health care services or treatments.

Plan Year: The plan year for benefits begins January 1 and ends December 31 of each year.

POS: Point-of-Service. An HMO plan that allows members to self-refer out of the network for most services, subject to higher fees than if care were received from the HMO network. Excludes preventive services.

PPO: Preferred Provider Organization. A network of medical care providers that provides various medical care services to covered employees and retirees for specified fees. Although fees charged by PPO providers are usually less than those charged by non-PPO providers, the employee or retiree may seek treatment from any provider.

Preauthorization: A Plan's prior approval is required for treatments or services.

Premium: The amount of money an employee or retiree pays for insurance coverage. A premium does not include additional copayments or deductibles incurred for treatment.

GLOSSARY

Primary Care Physician (PCP): The health care professional who belongs to an HMO or POS network and provides primary care for employees, retirees, or covered dependents. An employee or retiree must select a PCP when using an HMO or POS medical plan.

Primary Dental Office (PDO): The health care professional who belongs to an HMO or POS network and provides primary care for employees, retirees, or covered dependents. An employee or retiree must select a PDO when using a dental HMO or POS plan.

Provider: Any approved health care professional who provides treatment or services.

Qualified Medical Child Support Orders (QMCSO): A court order that requires a parent to provide health care coverage for dependent children.

Qualifying Event: An event such as marriage, divorce, or the birth of a child, that allows a change in health care coverage outside of the Open Enrollment period.

Retroactive Coverage: The process of paying back premiums to back date coverage to the date of the qualifying event.

State Subsidy: The portion of your insurance premium(s) that the State pays as a benefit to employees and retirees.

Summary Plan Description: A report describing the contents of a plan which must be provided to the plan participant.

Term Life Insurance: Insurance that provides death benefit coverage for a specified period, without permanent policy benefits such as cash or loan value.

TIAA-CREF: Teachers Insurance and Annuity Association - College Retirement Equities Fund. A nationwide retirement and annuity association set up for university and college employees.

INDEX

2004 State of Maryland Premium Rate Table

Medical Plans	Biweekly Medical Premiums			Monthly Medical Premiums		
Name of Plan	1 Person	2 People	3 + People	1 Person	2 People	3 + People
Blue Cross Blue Shield (PPO)	33.30	59.93	83.24	66.59	119.86	166.48
MLH-Eagle (PPO)	33.17	59.70	82.91	66.33	119.39	165.83
Aetna Quality (POS)	21.74	39.13	54.35	43.48	78.26	108.69
BCBS - Maryland (POS)	20.45	36.81	51.13	40.90	73.62	102.26
M.D.IPA Preferred (POS)	20.77	37.38	51.92	41.54	74.76	103.84
Blue Choice (HMO)	17.17	36.03	44.64	34.34	72.07	89.28
Kaiser Permanente (HMO)	16.05	32.10	40.20	32.10	64.19	80.40
Optimum Choice (HMO)	16.13	33.54	39.99	32.25	67.08	79.98

Prescription Plan Coverage Level	Biweekly Prescription Premium	Monthly Prescription Premium
Employee Only	$ 17.09	$ 34.19
Employee & One Child	$ 22.72	$ 45.43
Employee & Spouse	$ 28.37	$ 56.74
Employee & 2 or More	$ 34.19	$ 68.37

Dental Plans	Biweekly Dental Premiums			Monthly Dental Premiums		
Coverage Level	Dental Benefit Providers DHMO	United Concordia DHMO	United Concordia DPOS	Dental Benefit Providers DHMO	United Concordia DHMO	United Concordia DPOS
Employee Only	$ 3.46	$ 3.30	$ 4.45	$ 6.92	$ 6.60	$ 8.90
Employee & One Child	$ 6.92	$ 5.75	$ 7.76	$ 13.84	$ 11.50	$ 15.52
Employee & Spouse	$ 7.62	$ 6.61	$ 8.99	$ 15.23	$ 13.22	$ 17.98
Employee & 2 or More	$ 12.12	$ 9.29	$ 12.53	$ 24.23	$ 18.58	$ 25.06

The Term Life Insurance premiums for 2004 are located on the inside front cover of this book. The Term Life Insurance Plan is with Standard Insurance Company.

The AD&D premiums for 2004 are located on the inside front cover of this book. The AD&D plan is with the Metropolitan Life Insurance Company.

PLAN PHONE NUMBERS

Medical Plans

CareFirst Blue Cross Blue Shield PPO

- State Operations Center
  (410) 581-3601 (Baltimore)
  1-800-225-0131 (Outside Baltimore)
  (410) 998-7338 TTY/TDD
- Open Enrollment Hotlines
  (410) 581-3602 (Baltimore)
  1-800-852-4463 (Outside Baltimore)
  Website:
  www.carefirst.com/statemd

CareFirst Blue Cross Blue Shield Maryland POS

- State Operations Center
  (410) 581-0021 (Baltimore)
  1-800-203-2763 (Outside Baltimore)
  (410) 998-7338 TTY/TDD
- Open Enrollment Hotlines
  (410) 581-3602 (Baltimore)
  1-800-852-4463 (Outside Baltimore)
  Website:
  www.carefirst.com/statemd

CareFirst Blue Cross Blue Shield BlueChoice HMO

(410) 654-8675 (Baltimore)
1-800-445-6036 (Within Maryland)
(410) 605-2492 TTY/TDD
1-800-828-3196 TTY/TDD
Website:
www.carefirst.com/statemd

Kaiser Permanente HMO

1-800-777-7902 (Baltimore)
(443) 663-6181 (Baltimore)
(301) 468-6000 (Washington)
1-800-368-5784 (Washington)
(410) 339-5545 TTY/TDD (Baltimore)
(301) 816-6344 TTY/TDD (Washington)
Website:
www.KaiserPermanente.org

Aetna QPOS

1-888-287-4296
(1-888-287-4296 TTY/TDD
Website: www.aetna.com

MLH-EAGLE PPO (MAMSI)

1-800-447-6267
(301) 309-1710 TTY/TDD
Website: www.Mamsi.com

M.D. IPA Preferred POS (MAMSI)

1-800-447-6267
(301) 309-1710 TTY/TDD
Website: www.Mamsi.com

Optimum Choice HMO (MAMSI)

1-800-447-6267
(301) 309-1710 TTY/TDD
Website: www.Mamsi.com

Prescription Plan

AdvancePCS

1-800-345-9384
Website:
https://maryland.advancerx.com

Dental Plans

Dental Benefits Providers DHMO

1-877-566-3562
Website: www.dbp-inc.com

United Concordia DHMO and DPOS

1-888-MD-TEETH
(1-888-638-3384)
Website: www.ucci.com

Mental Health/Substance Abuse Plan

APS Healthcare, Inc. (APS)

1-877-239-1458
Website: www.APSHelpLink.com
MD State Code: SOM2002

Long Term Care Plan

Unum Life Insurance Co.

1-800-227-4165
Website: www.unums.com/enroll/maryland

Accidental Death and Dismemberment

Metropolitan Life Insurance Co.

1-888-842-2757
Website: www.metlife.com

Term Life Insurance Plan

Standard Insurance Co.

1-888-246-9002
Website: www.standard.com/mybenefits/maryland

Flexible Spending Account Administration

Erisa Administrative Services

1-888-966-FLEX (3539)
Website: www.flexmd.cserisa.com

Employee Benefits Division

301 West Preston Street, Room 510
Baltimore, MD 21201
(410) 767-4775
1-800-30-STATE (1-800-307-8283)
Website: www.dbm.maryland.gov (Click on "Employee Services")